

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 118 Sunset Drive	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle ROE Last ABBOTT		4. DATE OF DEATH Month May Day 31 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 21, 1898
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Medford Roe		14. MOTHER'S MAIDEN NAME Amanda Thompson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT J. Vernon Abbott Address 2			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Acute massive hepatic necrosis 092X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Acute viral hepatitis type A (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) INTERVAL BETWEEN ONSET AND DEATH 3 days 5 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) medford roe attended the deceased from 4/27 , 19 62 , to May 31 , 19 62 , that (I) medford roe last saw the deceased alive on May 31 , 19 62 , and that death occurred at 5:30 PM from the causes and on the date stated above.			
22a. SIGNATURE General Blunt M.D.		22b. DATE SIGNED 6/1/62	
22c. PHYSICIAN'S NAME (Type) GOVERN CHURCH		22d. ADDRESS 121 CATHERAZ ST ANNAPOLIS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-3-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff		23d. LOCATION (City, town or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor Sons		25a. REC'D BY REGISTRAR 4 '62 DATE	
25b. REGISTRAR'S SIGNATURE Arthur L. Hwang			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
05323													
05318													
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			d. STREET ADDRESS <u>302 E. Pasadena Rd.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>302 E. Pasadena Road</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Evalyn</u> Middle <u>F.</u> Last <u>Acree</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>18</u> Year <u>1962</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>31 Dec 1881</u>		9. AGE (In years last birthday) <u>80</u> yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						
13. FATHER'S NAME <u>Thornton Longest</u>					14. MOTHER'S MAIDEN NAME <u>Georgia Broach</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Name <u>Mrs. Sarah Lewis</u> Address <u>Same As #2</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CEREBRAL ATHEROSCLEROSIS</u> (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>2 YRS.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)					
21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 5-14 1962</u> , 19 <u>55</u> to <u>MAY 22 1962</u> , that (I) (we) last saw the deceased alive on <u>5-14 1962</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.										22a. SIGNATURE <u>Leon C. Perry</u>		22b. DATE SIGNED <u>5-18-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>LEON C. PERRY, M.D.</u>					22d. ADDRESS <u>201 BRADBURY, MD.</u>		22e. REC'D BY REGISTRAR <u>GLEN BURNIE, MD.</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>21st May 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>			23d. LOCATION (City, town or county) <u>Glen Burnie</u>			(State) <u>Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>K. V. Singleton</u>					ADDRESS <u>Glen Burnie, MD.</u>		25a. REC'D BY REGISTRAR <u>MAY 22 '62</u>		25b. REGISTRAR'S SIGNATURE				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

05324

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05319

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN b 2 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL - Edgewater			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Peter Middle P Last ALSQUITH SR				4. DATE OF DEATH Month May Day 14 Year 1962			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-30-1878	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83		IF UNDER 24 HRS. Hours 83 Min. 83			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY TOBACCO FARMER		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME GEORGE ASQUITH				14. MOTHER'S MAIDEN NAME MARY IRELAND			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) —				16. SOCIAL SECURITY NO. —			
17. INFORMANT ETHEL PHIPPS				Address FARMHUT RD. ANNAPOLIS MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 42011 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Carcinoma of pancreas INTERVAL BETWEEN ONSET AND DEATH sudden							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) the hospital attended the deceased from May 12, 1962 to May 14, 1962 , that (I) XX last saw the deceased alive on May 14, 1962 , and that death occurred at 1:10 PM , from the causes and on the date stated above.							
22a. SIGNATURE Jesse L. Wilkins M.D.							
22b. DATE 5/14/62							
22c. PHYSICIAN'S NAME (Type) Jesse L. Wilkins, M.D.							
22d. ADDRESS 98 Cathedral St., Annapolis, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL							
23b. DATE THEREOF 5-17-62							
23c. NAME OF CEMETERY OR CREMATORY Ahh Hahhous							
23d. LOCATION (City, town or county) (State) Birdsview Md.							
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons Annapolis, Md.							
25a. REC'D BY REGISTRAR DATE MAY 16 '62							
25b. REGISTRAR'S SIGNATURE Arthur L. Hines							

00318

STATEMENT OF DEATH

00318

(M)

NAME [unclear]

RESIDENCE [unclear]

DATE OF DEATH [unclear]

PLACE OF DEATH [unclear]

LOCALITY [unclear]

DATE OF DEATH [unclear]

RESIDENCE [unclear]

MARY IRELAND

CHILD [unclear]

DATE OF DEATH [unclear]

PLACE OF DEATH [unclear]

LOCALITY [unclear]

DATE OF DEATH [unclear]

PLACE OF DEATH [unclear]

LOCALITY [unclear]

DATE OF DEATH [unclear]

PLACE OF DEATH [unclear]

LOCALITY [unclear]

DATE OF DEATH [unclear]

PLACE OF DEATH [unclear]

LOCALITY [unclear]

DATE OF DEATH [unclear]

PLACE OF DEATH [unclear]

LOCALITY [unclear]

DATE OF DEATH [unclear]

PLACE OF DEATH [unclear]

LOCALITY [unclear]

98 [unclear] [unclear]

JOHN L. WILKINS, D.D.

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VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05325

05320

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Knollwood Manor, Millersville, Md.</u>		d. STREET ADDRESS <u>209 Greenland Beach Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM M. ALBIKER</u>		4. DATE OF DEATH <u>May 30 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 2, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>
13. FATHER'S NAME <u>George Albiker</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-05-6070</u>	
17. INFORMANT <u>Mrs. Juanita Walker, 209 Greenland Beach Rd.</u>		Address <u>Balto. 26, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Broncho pneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral disease chronic bronchitis and emphysema</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/25 12:05</u> to <u>5/30 1962</u> , that (I) (we) last saw the deceased alive on <u>5/29 1962</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Conrad Church</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>CONRAD CHURCH</u>		22d. ADDRESS <u>121 CATHERINE ST ANNAPOLIS</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 2, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Ritchie Hwy, A. A. Co. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>FLYNN & FLEMING, INC.</u>		25a. REC'D BY REGISTRAR <u>JUN 4 '62</u>	
ADDRESS <u>1422 Light St., Balto.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kerner</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05321	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Severn River near Old Severn River Bridge</u>					d. STREET ADDRESS <u>APL, U.S. Naval Academy</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Francisco</u> Middle <u>Alejo</u> Last <u>ALCAJARAS</u>					4. DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>19 62</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Malayan</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>20 July 1942</u>		9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TH STEWARD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>USN</u>		11. BIRTHPLACE (State or foreign country) <u>Philippines</u>			12. CITIZEN OF WHAT COUNTRY? <u>Philippines</u>		
13. FATHER'S NAME <u>Gabriel Alcajaras</u>					14. MOTHER'S MAIDEN NAME <u>Leonida A. Alejo</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>9/16/60 to</u>		17. INFORMANT <u>ICDR L.C. DERYN USN</u> Address <u>U.S. Naval Station Annapolis, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>850x Scumming</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Scumming</u> DUE TO (c) <u>Scumming</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Scumming</u> INTERVAL BETWEEN ONSET AND DEATH <u>Scumming</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>* Knocked in the water while attempting to raise the sail of a boat he was sailing alone.</u>											
20c. TIME OF INJURY Hour <u>11</u> P.M. Month, Day, Year <u>19 May 1962</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Severn River</u>		20f. (City or town) <u>Annapolis, Anne Arundel, Md.</u>		(County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>E. Linbrook</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <u>5/29/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>5/29/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Naval Shipyard</u>			22d. LOCATION (City, town, or county) (State) <u>50-7th St. San Francisco California</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Earl B. Wadsworth</u> ADDRESS <u>6306 - Belair Rd. Baltimore - 6, Md</u>						24a. REC'D BY REGISTRAR DATE <u>MAY 23 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

* Newspaper

7. *Barrett* 10. 11.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05322 CERTIFICATE OF DEATH 05322											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL - Edgewater				d. STREET ADDRESS Salisbury & Woodland Beach, Dr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Cecil Middle W Last AYLOR			4. DATE OF DEATH Month May Day 27 Year 1962								
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 11, 1911		9. AGE (In years last birthday) 50s		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Driver				10b. KIND OF BUSINESS OR INDUSTRY Taxi Driver		11. BIRTHPLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John L. Aylor						14. MOTHER'S MAIDEN NAME Bessie Whispell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mary E. Aylor			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Cerebral Hemorrhage, L. Hemiplegia (a), stating the underlying cause last. (c) General & Cerebral Arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) deceased attended the deceased from 5/24/62 to May 27, 1962 that (I) was last saw the deceased alive on May 26, 1962, and that death occurred at 1:30 AM, from the causes and on the date stated above.											
21a. SIGNATURE Maurice Klawans						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 5/28/62		
22c. PHYSICIAN'S NAME (Type) Maurice Klawans						22d. ADDRESS 31 Southgate Ave., Annapolis, Md.					
23a. BURIAL, CREMATION, REMOVAL? (Specify) Burial		23b. DATE THEREOF 5-29-62		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town or county) Washington		(State) D.C.			
24. FUNERAL DIRECTOR'S SIGNATURE John M. T aylor						ADDRESS Annapolis Md.		25a. REC'D BY REGISTRAR DATE MAY 29 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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Journal of Management Education

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LAUREL, MD c. LENGTH OF STAY IN 1b 7 years d. NAME OF HOSPITAL OR INSTITUTION (if in hospital, give street address) DISTRICT TRAINING SCHOOL CHILDREN'S CENTER, LAUREL, MD.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WASHINGTON, D.C. b. COUNTY 47X-3 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 1318 HOLBROOK ST. N.E. d. STREET ADDRESS 1318 HOLBROOK ST. N.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle LEE Last BALL						4. DATE OF DEATH Month MAY Day 16 Year 1962							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/20/53		9. AGE (In years last birthday) 9 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSTITUTIONALIZED				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME THEODORE ALBERT BALL						14. MOTHER'S MAIDEN NAME JUNE REBECCA SHARP							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ** (If yes give war or dates of service) **						16. SOCIAL SECURITY NO. **						17. INFORMANT Address CHILDREN'S CENTER, LAUREL, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration - pneumonia 325.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Mental retardation - cerebral agenesis (c) Convulsive disorder										INTERVAL BETWEEN ONSET AND DEATH 3 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) ---							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 5/13/55 to 5/16/62 , that (I) (we) last saw the deceased alive on 5/16/62 and that death occurred at 3:00pm from the causes and on the date stated above.													
22a. SIGNATURE James E. Boyland M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 5/16/62				
22c. PHYSICIAN'S NAME (Type) James E. Boyland, M.D.						22d. ADDRESS CHILDREN'S CENTER, LAUREL, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 5/19/62			23c. NAME OF CEMETERY OR CREMATORY Forest Lawn MEM. PARK CYPRESS, CALIFORNIA			23d. LOCATION (City, town or county) (State)				
24. FUNERAL DIRECTOR'S SIGNATURE Shirley J. Donaldson ADDRESS Laurel						25a. REC'D BY REGISTRAR DATE MAY 22 '62			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

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AGE ADULT

LABELL, JO 1 year

CHILDREN'S CENTER, LABELL, MO.

LABELL, MO.

White

INVESTIGATED

WEDGON ALBERT BAIL

WASHINGTON, D.C.

1310 HOLMWOOD ST. N.W.

ALL

3/30/52

WASHINGTON D.C.

JUNE HERBERT SPART

CHILDREN'S CENTER, LABELL, MO.

Aspiration - pneumonia

Mental retardation - cerebral palsy

Convulsive disorder

3/30/52

3/30/52

3/30/52

3/30/52

CHILDREN'S CENTER, LABELL, MO.

James E. Boyland, M.D.

3/30/52

James E. Boyland, M.D. 3/30/52

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05329 CERTIFICATE OF DEATH 05324

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE MD. b. COUNTY A. A. Co.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOHIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 ANNAPOLIS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 418 JEFFERSON ST.		d. STREET ADDRESS 418 JEFFERSON ST.	
3. NAME OF DECEASED (Type or print) First FLORENCE Middle J. Last BARRY		4. DATE OF DEATH Month 5 Day 26 Year 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-27-1901
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		9b. KIND OF BUSINESS OR INDUSTRY HOME	9c. AGE (In years last birthday) 60 yrs.
10a. BIRTHPLACE (County & State, or foreign country) ANNAPOLIS MD.		10b. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. FATHER'S NAME JAMES M. CASEY		12. MOTHER'S MAIDEN NAME JEANETTE CLARK	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		14. SOCIAL SECURITY NO. IRA J. BARRY #2	
15. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) 420.1 (c) Coronary artery disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (e) Cerebral Hemorrhage - Melanotic		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1960 to 5/26 , 1962 , that (I) (we) last saw the deceased alive on 5-26 , 1962 , and that death occurred 12:40 AM , from the causes and on the date stated above.			
22a. SIGNATURE E. L. Harkett		22b. DATE SIGNED 5/26/62	
22c. PHYSICIAN'S NAME (Type) E. L. Harkett		22d. ADDRESS Annapolis Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-30-62	23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF	23d. LOCATION (City, town or county) (State) ANNAPOLIS MD.
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons		25a. REC'D BY REGISTRAR MAY 29 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

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[Faint, illegible handwriting, likely bleed-through from the reverse side of the page. The text is mirrored and difficult to decipher.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05330

CERTIFICATE OF DEATH

05325

Item 1 FilmG312 5/8/62iwk

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 30 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) His residence- First Joseph Middle Vernon Last Becker				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Crownsville d. STREET ADDRESS 1 Rt #1 Box 19 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 19, 1900		9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter II				10b. KIND OF BUSINESS OR INDUSTRY Crownsville State Hospital				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Otto Becker				14. MOTHER'S MAIDEN NAME Annie M. Hepting											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes Serial No. 3,361,363				16. SOCIAL SECURITY NO. 220-36-6919				17. INFORMANT Bertha M. Becker Wife and Employment Records							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 199 X DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized Carcinosis (Primary Site Undisclosed) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -----											
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Crownsville		(County) Anne Arundel		(State) Md			
21. I certify that (I) (this hospital) attended the deceased from April 20, 1962 to May 1, 1962 , that (I) (we) last saw the deceased alive on May 1, 1962 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.															
22a. SIGNATURE L. Benedict, M. D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/1/62							
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.						22d. ADDRESS Crownsville State Hospital, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-4-62		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial				23d. LOCATION (City, town or county) Glen Burnie Md					
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons						ADDRESS Annapolis Md		25a. REC'D BY REGISTRAR MAY 3 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Klaus					

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James M. Jones

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 05326									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1 mo. 14 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston d. STREET ADDRESS Box 83 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) 3-#22051 John Wesley Boyce					4. DATE OF DEATH Month 5 Day 6 Year 19 62				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 15, 1897		9. AGE (in years last birthday) 64 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Donald Boyce				14. MOTHER'S MAIDEN NAME Laura					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-18-5840		17. INFORMANT Hospital Records Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia Due to Food Particles 921.7 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Generalized Arteriosclerosis								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Suddenly after supper he ceased breathing							
20c. TIME OF INJURY Month, Day, Year 6:30 p. m. 5 6 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Crownsville State Hospital		20f. (City or town) Crownsville (County) A. A. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE Elmer G. Linhardt				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 5/7/62	
EXAMINER'S NAME (Type) Elmer G. Linhardt, M. D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-12-62		22c. NAME OF CEMETERY OR CREMATORY Jonestown Cemetery		22d. LOCATION (City, town, or county) Preston Md (State)			
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton ADDRESS Federalsburg, Md						24a. REC'D BY REGISTRAR DATE MAY 14 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Thayer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
05332														
1. PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ellenburne</u> c. LENGTH OF STAY IN 1b <u>2 Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>608 Everett Rd</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md.</u> b. COUNTY <u>A. A. Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ellenburne</u> d. STREET ADDRESS <u>608 Everett Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Kurt Brieger</u>					4. DATE OF DEATH <u>May 21/62</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 29/03</u>		9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ellenburne</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Belmont St. appts</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>						
13. FATHER'S NAME <u>Julius Brieger</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>212-09-0378</u>					17. INFORMANT <u>Lina Brieger (Same)</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>156.1</u> DUE TO <u>CANCER of the Liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 19 1961</u> to <u>May 21 1962</u> that (I) (we) last saw the deceased alive on <u>May 18 1962</u> and that death occurred at <u>12:40 p.m.</u> from the causes and on the date stated above.														
22a. SIGNATURE <u>Henry Armanas</u> M.D.					22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <u>HENRY ARMANAS</u>					22d. ADDRESS <u>1934 Wilkens Ave. Baltimore 23, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5/24/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Louis</u>		23d. LOCATION (City, town or county) (State) <u>Balto. 29. Md</u>		23e. (State)						
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witke 10.4101 Edmondson</u> ADDRESS <u>am</u>					25a. REC'D BY REGISTRAR <u>DATE MAY 23 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>							

100.00

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(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05333

CERTIFICATE OF DEATH

05328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>36 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>31 Parole Street</u>		d. STREET ADDRESS <u>31 Parole Street</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ANN</u> Last <u>BROWN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>27</u> Year <u>19 62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 24-1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>*****</u>	
11. BIRTHPLACE (State or foreign country) <u>A.A.Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Warren</u>		14. MOTHER'S MAIDEN NAME <u>Louise Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Louvenia Embry-42 Parole St. Anna. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-17-62</u> 19 <u>62</u> , to <u>5-27-62</u> 19 <u>62</u> , that I last saw the deceased alive on <u>5-27-62</u> 19 <u>62</u> , and that death occurred at <u>6 L Cathedral St</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>A.T. Allen</u> M.D. <u>6 L Cathedral St</u> <u>5-29-62</u> PHYSICIAN'S NAME (Type) <u>A.T. Allen</u> <u>Cathedral Street-Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>May 30-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fowlers</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. HICKS III</u>		ADDRESS <u>Annapolis, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 4 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Keane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be received by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

05334

CERTIFICATE OF DEATH

05329

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severn			
d. NAME OF HOSPITAL (If not in hospital, give street address) Maryland Kimbrough Army Hospital Ft Geo. G. Meade				e. STREET ADDRESS Jacksongrove Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William S. Carter				4. DATE OF DEATH Month Day Year May 26 19 62			
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19 1900	
9. AGE (In years last birthday) yrs. 61		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired M. Sgt.				10b. KIND OF BUSINESS OR INDUSTRY N/A US Army		11. BIRTHPLACE (State or foreign country) Ruffin North Carolina	
13. FATHER'S NAME James Horace Carter				14. MOTHER'S MAIDEN NAME Lottie Price Chandler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 4/1/19-8/31/50				16. SOCIAL SECURITY NO. INFORMANT Mrs Wm S. Carter, Severn, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pulmonary Insufficiency 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 21 May , 19 62 , to 26 May , 19 62 , that I last saw the deceased alive on May 26 , 19 62 , and that death occurred at 3:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) US Army Hospital, Ft Meade, Md DATE SIGNED 26 May 62 ACTUAL SIGNATURE Sheldon Goldstein Captain PHYSICIAN'S NAME (Type) Sheldon Goldstein							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		5/31/62		Arlington National		Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert H. Boudreau				ADDRESS Severn, Md		24a. REC'D BY REGISTRAR DATE JUN 4 '62	
						24b. REGISTRAR'S SIGNATURE Arthur L. Chase	

40350

CERTIFICATE OF DEATH

1934

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSMF
5M 9/60

FOR STATE
HEALTH DEPT.

05335

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05330

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u> d. STREET ADDRESS <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>4 Y.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1202 Wilson Rd.</u>				4. DATE OF DEATH <u>May 7th.</u> 19 <u>62</u>			
3. NAME OF DECEASED (Type or print) <u>Amy E. Gonnard Caughy</u>		First Middle Last		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/5/75</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Eastbourne, England.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Baker</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Castle</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mrs. Marion Beavers, (daughter)</u>	
17. INFORMANT <u>Glen Burnie</u>		Address <u>1202 Wilson Rd</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Asthenia</u> <u>794X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) } (c), stating the underlying cause last. DUE TO (c) }		INTERVAL BETWEEN ONSET AND DEATH <u>5 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5-9-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>				22d. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR <u>Wm J. Jackson Sons Baltimore 19, Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 8 '62</u>			
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

10000

RECEIVED FROM THE DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

10000

RECEIVED FROM THE DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

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MEDICAL CERTIFICATION

VR A15 (4)
15M 7/61

Arthur S. Kraus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05337											
05331											
Item 6 Film G313 5/22/62 iwk											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Glen Burnie					
c. LENGTH OF STAY IN 1b 14 yrs.						d. STREET ADDRESS #1312 Howard Road (Harundale)					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) #1312 Howard Road (Harundale)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) GILBERT F.B. COLWELL						4. DATE OF DEATH May 9 19 62					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 19th July 1910		9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Proctor & Gamble				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph B. Colwell						14. MOTHER'S MAIDEN NAME Gertrude Lent					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. 215 03 6263					
17. INFORMANT Mrs. Dorothy F. Colwell						Address Same As #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardio-Vascular Disease INTERVAL BETWEEN ONSET AND DEATH											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Dec 53 May 62		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-5 1962, to 10:00 PM, that (I) (we) last saw the deceased alive on 5-5 1962, and that death occurred at 10:00 PM, from the causes and on the date stated above.											
22a. SIGNATURE Charles R. MacDonald M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 5-11-62		
22c. PHYSICIAN'S NAME (Type) Charles R. MacDonald						22d. ADDRESS 202 Crain Highway, S.W., Glen Burnie, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12th May 1962		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park				23d. LOCATION (City, town or county) Glen Burnie, Maryland (State)			
24. FUNERAL DIRECTOR'S SIGNATURE R.V. Sington						ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR MAY 15 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

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also bearing, No.

Serial

Charles A. Wickham

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death certificate is not obtained by the hospital or attending physician, it may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05332

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MD. b. COUNTY A.A.C.O.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PASADENA			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) BOX 409-RITCHIE HIGHWAY				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARIE ELIZABETH COMBS				4. DATE OF DEATH Month Day Year MAY 29 1962			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 16, 1890	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME THOMAS H. STODDARD				14. MOTHER'S MAIDEN NAME NELLIE T. HEAGERTY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT Address Mrs. Hawkins-Ritchie Hwy.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Arterio sclerotic Cardiovascular Dis. (c) 10 years				INTERVAL BETWEEN ONSET AND DEATH 1 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus, hypertension, osteoarthritis knees				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 1961 , to present , 19 62 , that (I) (we) last saw the deceased alive on 18 Apr 1962 and that death occurred at 1235 A M, from the causes and on the date stated above.							
22a. SIGNATURE C. Earl Hill				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 29 May 62	
22c. PHYSICIAN'S NAME (Type) C. EARL HILL				22d. ADDRESS 3708 Mountain Rd. Pasadena, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 6-1-62		23c. NAME OF CEMETERY OR CREMATORY Cathedral Cern.		23d. LOCATION (City, town or county) (State) Belts Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Foley Funeral Home - Catonsville, Md.				25a. REC'D BY REGISTRAR JUN 5 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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(M)

(A)

Handwritten notes, mostly illegible due to bleed-through from the reverse side of the page. Some words like "MAY 22" and "MAY 23" are visible.

Diabetic Mellitus, hypoglycemia, acute pancreatitis
18 Apr 62
C. EARL HILL
730 Mountain View Road
Birmingham, Alabama
29106

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>15 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1622 Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>226 N. Carey Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mamie</u> Middle <u>COTTMAN</u> Last <u>COTTMAN</u>		4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1892</u>	
9. AGE (in years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>15</u>	
11. IF UNDER 24 HRS. Hours <u>12</u> Min. <u>4</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 442 X DUE TO <u>Hypertensive Cardiovascular Renal Disease.</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <u>Arteriosclerosis - Generalized.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Decubitus Ulcers - Old Cerebrovascular Accident.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Baltimore</u> (County) <u>Baltimore</u> (State) <u>Md.</u>		20g. (City or town) <u>Baltimore</u> (County) <u>Baltimore</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/9/1962</u> to <u>5/19/62</u> , that (I) (we) last saw the deceased alive on <u>5/19/62</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Lashell M. Mapp</u> M.D. <u>Lionel M. Mapp</u>	
22b. DATE SIGNED <u>5/19/62</u>		22c. ADDRESS <u>2222 North Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 23, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		23d. LOCATION (City, town, or county) <u>Westport (Baltimore)</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jos L. Russ</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25c. DATE <u>MAY 22 1962</u>	

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RECEIVED BY DEPT. OF

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July 1917

Department of the Interior
Bureau of Land Management
Washington, D. C.

Very truly yours,
[Signature]
Special Agent in Charge
Bureau of Land Management
Department of the Interior
Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY in b 2 1/2 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riva d. STREET ADDRESS 12 Shore Walk, Silven Shores e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Estelle Middle O Last DRESSER		4. DATE OF DEATH Month May Day 8 Year 1962	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 26, 1891	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YL. R. Months 3 Days 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles W. Ogden		14. MOTHER'S MAIDEN NAME Virginia Robertson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Richard I. Dresser-Husbnad		Address same 2d	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) diabetes mellitus; Chn. Nephritis		INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) James attended the deceased from May 7, 1962 to May 8, 1962 , that (I) James last saw the deceased alive on May 8, 1962 , and that death occurred at 1:20 AM from the causes and on the date stated above.			
22a. SIGNATURE Maurice Klawans M.D.		22b. DATE SIGNED 5/8/62	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans, M.D.		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/11/62	
23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		25a. REC'D BY REGISTRAR May 14 '62	
ADDRESS Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Pumphrey	

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TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
05341											
05335											
1. PLACE OF DEATH a. COUNTY Anne Arundel Co. MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. Same b. COUNTY Same					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md.				c. LENGTH OF STAY IN 1b 5 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25, Md.				3V014	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Smuck's Dump						d. STREET ADDRESS 2807 Carver Rd.					
3. NAME OF DECEASED (Type or print) Harold Harper Edwards						4. DATE OF DEATH Month Day Year May 3 1962					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/9/33		9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkridge Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Herbert Edwards						14. MOTHER'S MAIDEN NAME Annebell Miles					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Pearl Edwards Same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest 812X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped off of back of truck and fell under wheel.							
20c. TIME OF INJURY Hour a.m. 11:00 May 3 1962				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Smuck's Dump		20f. (City or town) Glen Burnie		(County) A.A.Co. Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Gustave H. Faubert						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> May 3, 1962					
						Address (Street, city, town, or county) 2nd					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 5/6/62				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Mt Calvery Cemetary				22d. LOCATION (City, town, or country) Brooklyn Md.	
23. FUNERAL DIRECTOR Elroy O. Wilson 1000 Brantley Ave.						24a. REC'D BY REGISTRAR MAY 7 '62		24b. REGISTRAR'S SIGNATURE Cladburg S. Hanna			

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(M)

Herbert Edwards
Amabel
Frank Edwards
Emma

Burial 5/8/62
Edw. O. Wilson 1000 Bramble Ave.
Mt Calvary Cemetery Brooklyn N.Y.

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FOR STATE
HEALTH DEPT.

TO DEF. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05342

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05336

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Edgewater			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS Woodland Beach			
3. NAME OF DECEASED (Type or print) ROY L FOSTER				4. DATE OF DEATH Month May Day 13 Year 19 62			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/27/14	
9. AGE (In years last birthday) 47 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tree Trimmer		11. BIRTHPLACE (State or foreign country) Tenn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ephram Foster				14. MOTHER'S MAIDEN NAME Margaret (Unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 406-09-7164		17. INFORMANT Address Fanny Foster- Wife- same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of the left chest 976 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest					
20c. TIME OF INJURY Hour 8:00 p.m. Month, Day, Year 5/12 19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Edgewater, Anne Arundel, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Peter W. Rieckert		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Medical Investigator x				DATE SIGNED 5/14/62	
EXAMINER'S NAME (Type) Peter W. Rieckert, M.D.		Address (Street, city, town, or county) Rt 2 Oneida, Tenn.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial May 15, 1962		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Cross Roads Cemetery		22d. LOCATION (City, town, or country) (State) Rt 2 Oneida, Tenn.	
23. FUNERAL DIRECTOR HOPPING FUNERAL HOME				ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR MAY 18 '62	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thana			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN H 4 yrs. 4 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			3101-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital					d. STREET ADDRESS 1223 E. Lanvale Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Hattie Middle Spencer Last Gardmon					4. DATE OF DEATH Month 5 Day 3 Year 1962					
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 1, 1882		9. AGE (In years last birthday) 80 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Joe Spencer					14. MOTHER'S MAIDEN NAME Susie ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General and Cerebral Arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH Hours Years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from 1/6 , 19 58 , to 5/3 , 19 62 , that (I) (we) last saw the deceased alive on 5/3 , 19 62 , and that death occurred at 5:30 a.m. , from the causes and on the date stated above.										
22a. SIGNATURE <i>Lionel McHenry Mapp</i> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> May 3, 1962		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.					22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-6-62		23c. NAME OF CEMETERY OR CREMATORY St. Calvary Cem		23d. LOCATION (City, town or county) (State) Q. A. Co Md				
24. FUNERAL DIRECTOR'S SIGNATURE <i>Rayner Sandere</i>					ADDRESS 217 E. Preston St		25a. REC'D BY REGISTRAR MAY 8 '62		25b. REGISTRAR'S SIGNATURE <i>William S. Kline</i>	

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OFFICE OF THE

PROSECUTOR GENERAL
STATE OF NEW YORK
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REPORT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
05344											
05338											
1. PLACE OF DEATH a. COUNTY <i>AA</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN 1b <i>10</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>167 Gloucester St</i>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>AA</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> d. STREET ADDRESS <i>167 Gloucester St</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Hattie V. Lessor</i>						4. DATE OF DEATH Month <i>May</i> Day <i>17</i> Year <i>1962</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 11th 1879</i>		9. AGE (In years last birthday) <i>83</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Seamstress</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Dress making</i>				11. BIRTH PLACE (County & State, or foreign country) <i>Annapolis</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Charles H. Obery</i>				14. MOTHER'S MAIDEN NAME <i>Bertha L. Weaver</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>213-16-1668</i>		17. INFORMANT Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <i>Arteriosclerotic Heart Disease</i> (c) <i>1 yr</i>										INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>1 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 1, 1959</i> to <i>Jan 5, 1962</i> , that (I) (we) last saw the deceased alive on <i>Jan 5, 1960</i> , and that death occurred at <i>AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>James R. Martin</i> 22c. PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <i>6 SHAW ST. ANNAPOLIS, MD</i>		22b. DATE SIGNED <i>5/17/62</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 19th 1962</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St Marys Cem</i>		23d. LOCATION (City, town or county) (State) <i>Annapolis Md</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Surs</i>				ADDRESS <i>Annapolis Md</i>		25a. REC'D BY REGISTRAR <i>MAY 21 62</i>		25b. REGISTRAR'S SIGNATURE <i>Robert L. Haines</i>			

1883

1883

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James R. Nelson
Caretaker of the
Green Mountain

James R. Nelson
Caretaker of the
Green Mountain

CERTIFICATE OF DEATH

05339

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN IB 5 mos. 16 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2322 McCulloh Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last 3-#23022 Anna Estelle (Essie) Green		4. DATE OF DEATH Month Day Year 5 7 19 62	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1876
9. AGE (In years last birthday) 86		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Charles Stewart		14. MOTHER'S MAIDEN NAME Martha ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiovascular Disease 443X Conditions, if any, which gave rise to immediate cause (b) (c) (e), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Osteomyelitis, Right Leg			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. --- p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----
20f. (City or town) -----		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/21 6:15 to 5/7 62 , that (I) (we) last saw the deceased alive on 5/7 62 , and that death occurred at A.M. from the causes and on the date stated above.			
22a. SIGNATURE Hildegard Heard Reissman M.D.		22b. DATE 5/7/62	
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/12/62	23c. NAME OF CEMETERY OR CREMATORY Carver Mem. Park
23d. LOCATION (City, town or county) Laurel Maryland		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Herbert E. Nutter		25. REC'D BY REGISTRAR 3035 W North Ave DATE MAY 9 '62	
25b. REGISTRAR'S SIGNATURE Caroline S. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



05346

CERTIFICATE OF DEATH

05340

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis			
c. LENGTH OF STAY IN 1b 1 wk				d. STREET ADDRESS 194 Clay St.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital							
3. NAME OF DECEASED (Type or print) Nannie Evelyn GREEN				4. DATE OF DEATH Month May Day 10 Year 1962			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 17, 1895	
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 6 Days 10		11. IF UNDER 24 HRS. Hours 10 Min. 10			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. Known		17. INFORMANT Robert Green Sr. 194 Clay St. Anna. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage due to arterial sclerosis DUE TO (b) Hypertension DUE TO (c) Cardiovascular disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5/4		20f. (City or town) (County) (State) Annapolis, Maryland	
21. I certify that (I) (the undersigned) attended the deceased from May 10, 1962 , to May 10, 1962 , that (I) (we) saw the deceased alive on May 10, 1962 , and that death occurred at 5/4 M, from the causes and on the date stated above.							
22a. SIGNATURE R. L. Richardson				22b. DATE SIGNED 6:45 PM			
22c. PHYSICIAN'S NAME (Type) R. L. Richardson, M.D.				22d. ADDRESS 110 Clay St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 13-62		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town or county) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks III				25a. REC'D BY REGISTRAR May 16 '62			
25b. REGISTRAR'S SIGNATURE Arthur S. Hume							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00340

(M)

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Dr. J. H. ...
Dr. J. H. ...
Dr. J. H. ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) William E. Green		2. DATE OF DEATH 5-20-62				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND Anne Arundel County FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 309 Riverview Rd.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Anne Arundel C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural give location) 309 RIVERVIEW Rd.				
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Wid.	8. DATE OF BIRTH 2-4-90	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) W.M.R.R. RETIR.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSHUA GREEN		14. MOTHER'S MAIDEN NAME ELLEN DEBOW		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS FAMILY - AS ABOVE				
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 422.1		CAUSE OF DEATH (A) Chronic Myocardial Degeneration DUE TO (B) Arteriosclerosis DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 2 yrs.		
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 5-20-1962 that (I) (we) last saw the deceased alive on 5-19-1962 and that in (my) (our) opinion death occurred at 10A. m. from the causes and on the date stated above.						
23A. SIGNATURE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. G. S. S. S.		23B. ADDRESS 707 E. Fort Ave.		23C. DATE SIGNED 5-21-62		
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 5-24-62	24C. NAME OF CEMETERY OR CREMATORY GLEN HAVEN		24D. LOCATION (City, town, or county) (State) BALTO. MD.		
25A. DATE REC'D BY HEALTH DEPT. MAY 22 '62		25B. NAME OF REGISTRAR Arthur S. Thomas		25C. FUNERAL DIRECTOR ADDRESS McGully Funeral Home		



PLACE OF BIRTH
A. COUNTY

REMARKS

A. STATE

DATE OF BIRTH
YEAR MONTH DAY

CHURCH OF CHRIST
MEMBER

DATE OF BIRTH
YEAR MONTH DAY

CHURCH OF CHRIST
MEMBER

PLACE OF BIRTH
A. COUNTY

REMARKS

A. STATE

DATE OF BIRTH
YEAR MONTH DAY

CHURCH OF CHRIST
MEMBER

DATE OF BIRTH
YEAR MONTH DAY

CHURCH OF CHRIST
MEMBER

REMARKS

DATE OF BIRTH
YEAR MONTH DAY

CHURCH OF CHRIST
MEMBER

A. STATE

REMARKS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

05348

05342

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY A-ARUNDEL CO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE P.O.		c. LENGTH OF STAY IN 1b 2 YRS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21-1ST AVE MARLEY PARK, MD.		d. STREET ADDRESS 604 ANIKAP RD.	
3. NAME OF DECEASED (Type or print) First Middle Last MATTIE GERTRUDE GRIMES		4. DATE OF DEATH Month Day Year MAY 11 1962	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 NOV 1880
9. AGE (In years last birthday) yrs. 81		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) FINCASTLE, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? YES	
13. FATHER'S NAME GEORGE W. BAKER (DEC)		14. MOTHER'S MAIDEN NAME MARY LUGER (DEC)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS MOLLIE WATKINS (daughter)		Address SAME ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIAC EDEMA 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIO SCLEROTIC HEART DISEASE			INTERVAL BETWEEN ONSET AND DEATH SUDDEN 4 mo 20 YRS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year Hour o. m. X p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X		20f. (City or town) (County) (State) X	
21. I certify that I attended the deceased from 1 APRIL 1962 , to PRESENT , 19 62 , that I last saw the deceased alive on 27 APRIL 1962 , and that death occurred at 5⁰⁰ A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H.F. Manuzak		M.D. 425 S. RITCHIE HWY 11 MAY 62	
PHYSICIAN'S NAME (Type) H.F. MANUZAK		GLEN BURNIE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/15/62	22c. NAME OF CEMETERY OR CREMATORY Flushing Cemetery	22d. LOCATION (City, town, or county) (State) Flushing Ohio
23. FUNERAL DIRECTOR'S SIGNATURE Hooping & Kirkley		ADDRESS Glen Burnie Md.	
24a. REC'D BY REGISTRAR DATE MAY 17 '62		24b. REGISTRAR'S SIGNATURE William S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

12
05349
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
06399

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 1311 West St.,	
3. NAME OF DECEASED (Type or print) First Gardiner Middle A Last HALL		4. DATE OF DEATH Month May Day 9 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1906
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months 55 Days 9 Hours 1962 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housing Authority EXAC. for Annapolis City		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Amos L. Hall		14. MOTHER'S MAIDEN NAME Betty C. Patterson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Dorothy W. Hall	
17. INFORMANT Dorothy W. Hall		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease DUE TO (c) 2 years		INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) Richard I. Hochman attended the deceased from Jan. 20, 1962 , to May 9, 1962 , that (I) see last saw the deceased alive on May 9, 1962 , and that death occurred at 6:20 AM from the causes and on the date stated above.		22a. SIGNATURE Richard I. Hochman M.D.	
22b. DATE SIGNED 5/9/62		22c. ADDRESS 59 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 11 1962	23c. NAME OF CEMETERY OR CREMATORY Mt. Harmony Cemetery	23d. LOCATION (City, town or county) (State) Calvert Co Md
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		25a. REC'D BY REGISTRAR DATE MAY 15 '62	
ADDRESS Annapolis Md		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

05350

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>D. ACO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.D.M. Anne Arundel Sen.</u>		d. STREET ADDRESS <u>1307 N. Hammonds Ferry Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Shel</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-11</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Friendship Airport</u>	
11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Silas Hall</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Grassion</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>2-13-20-9739</u>	
17. INFORMANT <u>Mrs. Harriett I. Hall</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> DUE TO <u>434.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>5/30/62</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>22 June '62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		ADDRESS <u>Glen Burnie MD.</u>	
24a. REC'D BY REGISTRAR <u>JUN 1 '62</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Haines</u>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1-3-30

(M)

TESTED BY X-702
MAY 1930

1-3-30

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN b. <u>1312 West St.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Homewood N/H</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Paladena</u> d. STREET ADDRESS <u>RT. 6-Box 135- High Point</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CYRUS B HAYNIE</u>		4. DATE OF DEATH <u>5 29 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 Dec. 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Revere Cop. & Brass</u>	9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>29</u> IF UNDER 24 HRS.: Hours <u>19</u> Min. <u>62</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown)</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-10-9896</u>	
17. INFORMANT <u>Mr. Thomas Haynie</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROSIS, GENERALIZED</u> DUE TO (c) <u>UNKNOWN</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/28, 1962</u> to <u>5/29, 1962</u> that (I) (we) last saw the deceased alive on <u>5/28, 1962</u> and that death occurred at <u>11 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u> M.D.		22b. DATE SIGNED <u>5/30/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK M.D.</u>		22d. ADDRESS <u>71 FRANKLIN ST ANNAPOLIS MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>31 May 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Pk.</u>	23d. LOCATION (City, town or county) (State) <u>Glen Burnie Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u>		25a. REC'D BY REGISTRAR <u>JUN 1 '62</u>	
ADDRESS <u>Glen Burnie, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Paine</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05352

05346

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY in lb <u>1 mo. 13 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Baltimore City</u> g. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> h. STREET ADDRESS <u>624 W. Franklin Street</u> i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>3-#23224 William A. Hollin</u>		4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 3, 1898</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffer</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Hollin</u>	
14. MOTHER'S MAIDEN NAME <u>Nancy Roberts</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>570.4</u> DUE TO <u>Paralytic Ileus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Obstruction of Small Intestines</u> (c) <u>Fecal impaction and Old Peritoneal Adhesions</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u> <u>2 days</u> <u>years</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>	
20c. TIME OF INJURY Hour <u>-----</u> e.m. <u>-----</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	20f. (City or town) (County) (State) <u>-----</u>
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1/17</u> to <u>5/10</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>5/10</u> , 19 <u>62</u> , and that death occurred at <u>2:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Hildegard Heard Reissman</u> M.D.		22b. DATE SIGNED <u>5/10/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissman, M. D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>5.15.62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEM. ARLINGTON, VIRGINIA</u>	23d. LOCATION (City, town or county) (State) <u>-----</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert F. M. Linn 1820-7884 N.W. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 14 '62</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

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BRITISH PATENT OFFICE, LONDON, ENGLAND

THE PATENT OFFICE, LONDON, ENGLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05353

Item 9 Film G313 5/21/62 iwk

05347

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS c. LENGTH OF STAY IN 1b ANNAPOLIS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. NAVAL HOSPITAL, ANNA, MD.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X ANNAPOLIS, d. STREET ADDRESS RT #3 BOX 145 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ETNA VIRGINIA HORNBERGER		4. DATE OF DEATH Month Day Year MAY 13 19 62	
5. SEX FEMALE	6. COLOR OR RACE CAUC	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 NOV 1877
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days 84 105	
11. IF UNDER 24 HRS. Hours Min. 10 5		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MARYLAND	
13. FATHER'S NAME JOHN ADAM JERSCHIED		14. MOTHER'S MAIDEN NAME ELIZABETH ELWIG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. JOHN ADAM HORNBERGER RT3 BOX 145 ANNA, MD	
17. INFORMANT JOHN ADAM HORNBERGER RT3 BOX 145 ANNA, MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line (or (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac decompensation. 420.0 DUE TO (b) Arterio sclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (c) 10 yrs. (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Renal cell carcinoma with metastasis			
INTERVAL BETWEEN ONSET AND DEATH 6 months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9 May 1962 , to 13 May 1962 , that (I) (we) last saw the deceased alive on 2 May 1962 , and that death occurred at 11:40 PM , from the causes and on the date stated above.			
22a. SIGNATURE George P. Wilson M.D.		22b. DATE SIGNED 14 MAY 62	
22c. PHYSICIAN'S NAME (Type) GEORGE P. WILSON LT MC USNR		22d. ADDRESS USNH ANNAPOLIS, MARYLAND (STAFF)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 17-62	
23c. NAME OF CEMETERY OR CREMATORY Cedar Bluff Cent Annapolis Md		23d. LOCATION (City, town or county) (State) Annapolis Md	
24. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons Annapolis Md		25a. REC'D BY REGISTRAR MAY 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05354 CERTIFICATE OF DEATH 05348

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Box-417	
3. NAME OF DECEASED (Type or print) ANNIE JACKSON		4. DATE OF DEATH May 6 19 62	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1895
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY House	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Theodous White		14. MOTHER'S MAIDEN NAME Annie Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT James W. Jackson-Box 417 Severna Park, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 422.1 DUE TO (b) Arteriosclerotic C-V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) misheard attended the deceased from 1955 , 19 to May 6, 1962 that (I) xxx last saw the deceased alive on May 6, 1962 , and that death occurred at M from the causes and on the date stated above.			
22a. SIGNATURE Robert R. Hahn M.D.		22b. DATE SIGNED 5-7-62	
22c. PHYSICIAN'S NAME (Type) Robert R. Hahn, M.D.		22d. ADDRESS Gov. Ritchie Hgwy., Severna Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 17-62	
23c. NAME OF CEMETERY OR CREMATORY Carpenters Hill		23d. LOCATION (City, town or county) (State) Severna Park-Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C.E.Hicks III		24b. ADDRESS Annapolis, Md.	
25a. REC'D BY REGISTRAR MAY 16 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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Anna Arnold

Anna Arnold

Anna Arnold

Anna - Governor Park

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Anna Arnold General Hospital

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TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

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FOR STATE
HEALTH DEPT.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel																																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEALE												c. LENGTH OF STAY IN 1b 10 yrs																																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)												d. STREET ADDRESS																																			
3. NAME OF DECEASED (Type or print) First Middle Last Christian Johnson												4. DATE OF DEATH Month Day Year May 15 19 62																																			
5. SEX Male				6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 11/5/1900				9. AGE (In years last birthday) 60? yrs.				IF UNDER 1 YEAR Months Days				IF UNDER 24 HRS. Hours Min.																							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter												10b. KIND OF BUSINESS OR INDUSTRY Commercial												11. BIRTHPLACE (State or foreign country) Christiania, Norway												12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Christina Littleson												14. MOTHER'S MAIDEN NAME Anna Johansen																																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWI												16. SOCIAL SECURITY NO. 579 145619												17. INFORMANT JAMES E. Payne 3407 Boston Lake Falls Church, Va																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 890.0 Acute carbon-monoxide poisoning DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH																																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in bed in kitchen - may have been defective gas refrigerator																																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7 55X 5/15/62												20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> el work <input type="checkbox"/> el work <input checked="" type="checkbox"/>												20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Residence												20f. (City or town) Deale (County) Anne Arundel (State) Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												CHIEF MEDICAL EXAMINER <input type="checkbox"/>												DATE SIGNED																							
ACTUAL SIGNATURE R Breitenecker												ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>												DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																							
EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D.												Address (Street, city, town, or county) May 15, 1962																																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial												22b. DATE THEREOF 5/18/62												22c. NAME OF CEMETERY OR CREMATORY ARLINGTON National												22d. LOCATION (City, town, or country) Fort Myer, Va (State)											
23. FUNERAL DIRECTOR Bernard Hardisty												ADDRESS Solisville road												24a. REC'D BY REGISTRAR DATE MAY 21 '62												24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05356

05350

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1 mo. 2 wks. 5 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Estelle Johnson				4. DATE OF DEATH Month 5 Day 3 Year 1962			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 17, 1923	9. AGE (In years last birthday) 39 yrs.	IF UNDER 1 YEAR Months 3 Days 10	IF UNDER 24 HRS. Hours 11 Min. 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? US.A.							
13. FATHER'S NAME Thomas Taylor				14. MOTHER'S MAIDEN NAME Sarah ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. Unknown			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Cryptococcal Meningitis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Chronic Brain Syndrome due to Alcoholism. CNS Syphilis (c) Chronic Brain Syndrome due to Alcoholism. CNS Syphilis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Hour e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 3/14 , 19 62 , to 5/3 , 19 62 , that (I) (we) last saw the deceased alive on 5/3 , 19 62 , and that death occurred at 11:30 a.m. from the causes and on the date stated above.							
22a. SIGNATURE Lionel McHenry Mapp				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED May 4, 1962	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/8/62		23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY Cem.		23d. LOCATION (City, town or county) (State) Brooklyn Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E.O. Wilson				ADDRESS 1000 Brawley Ave.		25a. REC'D BY REGISTRAR MAY 7 '62	
				25b. REGISTRAR'S SIGNATURE Arthur L. Hanes			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR A15 (4)
ISM 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
05357									
05351									
1. PLACE OF DEATH a. COUNTY Anne Arundel					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville					c. LENGTH OF STAY IN 1b 2 mos. 19 days				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital					d. STREET ADDRESS 2233 Orem Avenue				
3. NAME OF DECEASED (Type or print) 3-#23545 Wallace L. Keys					4. DATE OF DEATH Month 5 Day 22 Year 1962				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 17, 1904		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY HAULING		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13. FATHER'S NAME Ignatius Keys		14. MOTHER'S MAIDEN NAME Ida		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure									
DUE TO (b) Myocardial Infarction									
DUE TO (c) Coronary Sclerosis and Thrombosis									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19									
20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 5/22/62 to 5/22/62 , that (I) (we) last saw the deceased alive on 5/22/62 , and that death occurred at 12:40 M, from the causes and on the date stated above.									
22a. SIGNATURE Lionel McHenry Mapp, M. D.					22b. DATE SIGNED 5/22/62				
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.					22d. ADDRESS Crownsville State Hospital, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 5-26-62				
23c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEM.					23d. LOCATION (City, town or county) (State) BALTO. MD.				
24. FUNERAL DIRECTOR'S SIGNATURE Pres. J. Cooper					25a. REC'D BY REGISTRAR MAY 23 '62				
25b. REGISTRAR'S SIGNATURE Arthur L. Thomas									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena c. LENGTH OF STAY IN 1b 35 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 3911 Mountain Road		2. USUAL RESIDENCE (Where deceased lived, If institutions: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS 3911 Mountain Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna Catherine Kreppel First Middle Last		4. DATE OF DEATH May 29, 1962 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1905
9. AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Ventron	
14. MOTHER'S MAIDEN NAME Victoria Unk.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 17. INFORMANT Mr. William Kreppel Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 260 X DUE TO Coronary arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO diabetes mellitus (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) none		INTERVAL BETWEEN ONSET AND DEATH 30 minutes 5 years 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 30, 1949, to May 29, 1962, that (I) (we) last saw the deceased alive on May 27, 1962, and that death occurred at 10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE R.M. McLaughlin M.D.		22b. DATE SIGNED 5/29/62	
22c. PHYSICIAN'S NAME (Type) R.M. McLaughlin		22d. ADDRESS 3708 Mountain Rd. Pasadena 4, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF June 2, 1962	23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cem.	23d. LOCATION (City, town or county) (State) O'Donnell St. Balto., Md.
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce ADDRESS 4001 Ritchie Hwy. (25)		25a. REC'D BY REGISTRAR DATE JUN 4 '62 25b. REGISTRAR'S SIGNATURE Arthur S. Thoms	

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4000 Illinois St. (S)
Chicago, Ill.
U.S. Dept. of Justice
Federal Bureau of Investigation

14
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05359 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05353

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a physician is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Florida b. COUNTY Fort Lauderdale			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Linthicum				c. LENGTH OF STAY IN 1b Few instants			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Baltimore-Washington Expressway				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ralph Pierce Lawson				4. DATE OF DEATH May 30th, 1962			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/21/95	
9. AGE (in years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired telephone engineer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) East Pepperell, Mass.	
13. FATHER'S NAME Roswell Lawson				14. MOTHER'S MAIDEN NAME Laura Pierce			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. Mrs. Downy Lawson (wife)			
17. INFORMANT Mrs. Downy Lawson (wife)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260x DUE TO Conditions, if any, which gave rise to immediate cause (b) Diabetes (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden ?							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 5/30/62 DATE SIGNED			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) Glen Burnie, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 2, 1962		22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		22d. LOCATION (City, town, or county) (State) West Haven, Conn.	
23. FUNERAL DIRECTOR Hopping and Kirkley, Glen Burnie, Md.				24a. REC'D BY REGISTRAR JUN 4 '62			
				24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>			

(M)

Burial June 2, 1962 Oak Grove Cemetery
Hopping and Kinkley, Alan Morris, Md.
West Haven, Conn.

05360

CERTIFICATE OF DEATH

05354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE X			
d. NAME OF HOSPITAL (If not in hospital, give street address) 7428 Van Noy Loop				d. STREET ADDRESS 7428 Van Noy Loop 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Daniel Middle Joseph Last Leary				4. DATE OF DEATH Month May Day 14 Year 19 62			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1 Oct 1943	
9. AGE (In years last birthday) 18 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel F. Leary				14. MOTHER'S MAIDEN NAME Margaret J. Vestrocy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -			
INFORMANT Military I.D. Card				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia 754.5 DUE TO Congenital heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Jan 1962 1943							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 May , 19 62 , to 14 May , 19 62 , that I last saw the deceased alive on _____, 19 _____, and that death occurred at 9:22 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel J. Mangus				ADDRESS (Street, city or town, state) KIMBROUGH ARMY HOSPITAL FT GEORGE G MEADE, DATE SIGNED MD			
PHYSICIAN'S NAME (Type) SAMUEL J. MANGUS, CAPTAIN, MC				ADDRESS KIMBROUGH ARMY HOSPITAL FT GEORGE G MEADE, DATE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/17/62		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Seant Donaldson Laurel Md				24a. REC'D BY REGISTRAR DATE MAY 17 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05361

05355

1. PLACE OF DEATH e. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gleij Burnie d. STREET ADDRESS 103 2nd Ave., S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bertha Middle (Bertie) Last LOWMAN				4. DATE OF DEATH Month May Day 4 Year 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 4, 1892	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John T. Lowman				14. MOTHER'S MAIDEN NAME Sarah Hood			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-16-1122A		17. INFORMANT Mrs Dorothy Warfield-		Address same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 422.1 DUE TO (b) Arteriosclerotic Cardiovascular Dis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) Yes				INTERVAL BETWEEN ONSET AND DEATH 6 da.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Allergic reaction to penicillin				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) Richard N. Pecker attended the deceased from Apr. 29 , 19 62 to May 4 , 19 62 , that (I) XX last saw the deceased alive on May 4 , 19 62 , and that death occurred at 9:22 AM from the causes and on the date stated above.							
22a. SIGNATURE Richard N. Pecker				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/6/62	
22c. PHYSICIAN'S NAME (Type) RICHARD N. PECKER				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 7, 1962		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d. LOCATION (City, town or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley				ADDRESS Glen Burnie, Md.		25a. REC'D BY REGISTRAR MAY 8 '62	
				25b. REGISTRAR'S SIGNATURE Caroline S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

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John T. Howard

Married

John T. Howard

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05362

CERTIFICATE OF DEATH

05356

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt-1, Box-378	
3. NAME OF DECEASED (Type or print) William MC CARTER		d. STREET ADDRESS Rt-1, Box-378	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 5, 1899	
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop.		10b. KIND OF BUSINESS OR INDUSTRY Mariana	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas A. McCarter		14. MOTHER'S MAIDEN NAME Annie Porter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Uremia associated with 180x DUE TO hypocalcemia secondary to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO undifferentiated adenocarcinoma of left kidney (c) and metastatic to symphysis pubis		INTERVAL BETWEEN ONSET AND DEATH 24 hours 6 weeks 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) and metastatic to symphysis pubis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (we) attended the deceased from May 17, 1962 to May 17, 1962 , that (I) (we) last saw the deceased alive on May 17, 1962 , and that death occurred at 3:15 PM from the causes and on the date stated above.		22a. SIGNATURE Sylvia M. Lini M.D.	
22b. DATE 5/18/62		22c. PHYSICIAN'S NAME (Type) Sylvia Lini, M.D.	
22d. ADDRESS Mayo Road, Edgewater, Md.		22e. REC'D BY REGISTRAR DATE MAY 21 '62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 20, 1962	
23c. NAME OF CEMETERY OR CREMATORY Mayo Memorial Cemetery		23d. LOCATION (City, town or county) (State) Mayo, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		25b. REGISTRAR'S SIGNATURE Arthur S. House	
ADDRESS Annapolis, Md.		DATE	

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Anne Arnold General Hospital

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Thomas A. Holmstrom

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Sylvia L. H. D.

May 20, 1962 Rejoice in the Company

Rejoice in the Company, No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Baltimore City					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville						c. LENGTH OF STAY IN 1b 2 mos. 13 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore					
d. STREET ADDRESS 1430 Carroll Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) 3-#23450 Leon						4. DATE OF DEATH Month 5 Day 28 Year 19 62					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1903		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 5 Days 28	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Jack McDonald						14. MOTHER'S MAIDEN NAME Katie					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia 570.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Sub arachnoid hemorrhage (c) Paralytic Illness DUE TO cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Month, Day, Year Hour e.a. ----- p.m. 19				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/15 1962 , to 5/28 1962 , that (I) (we) last saw the deceased alive on 5/28 1962 , and that death occurred at 6:15 P.M. , from the causes and on the date stated above.											
22a. SIGNATURE Lionel McHenry Mapp, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 5/29/62			
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.						22d. ADDRESS Crownsville State Hospital, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/3/62		23c. NAME OF CEMETERY OR CREMATORY Summerton				23d. LOCATION (City, town or county) (State) Summerton, S.C.			
24. FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice						ADDRESS 661 W. Barre St.		25a. REC'D BY REGISTRAR Don S. 62		25b. REGISTRAR'S SIGNATURE Arthur S. Francis	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05364

05358

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY in lb 1 hr.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS Avalon Shores	
3. NAME OF DECEASED (Type or print) First Herman Middle John Last MEYER		4. DATE OF DEATH Month May Day 8 Year 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 10 1886 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oil Burner Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Heating	
11. BIRTHPLACE (County & State, or foreign country) ST. LOUIS, MISSOURI		12. CITIZEN OF WHAT COUNTRY? MO	
13. FATHER'S NAME John Meyer		14. MOTHER'S MAIDEN NAME Weber	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) UN KNOWN		16. SOCIAL SECURITY NO. MARIE C MEYER SHADYSIDE MD	
17. INFORMANT MARIE C MEYER SHADYSIDE MD		18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arteriosclerotic heart disease DUE TO (c) 2 hours INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Bronchial asthma		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) James attended the deceased from Jan , 1962, to May 8 , 1962, that (I) James last saw the deceased alive on May 8 , 1962, and that death occurred at 10:36 PM from the causes and on the date stated above.		22a. SIGNATURE Willard F. Smith MD M.D.	
22b. PHYSICIAN'S NAME (Type) Willard F. Smith, M.D.		22c. ADDRESS Shadyside, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 10 1962	
23c. NAME OF CEMETERY OR CREMATORY Woodfield		23d. LOCATION (City, town or county) (State) Laurelsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Baronard Hardisty		25a. REC'D BY REGISTRAR 15 '62	
25b. REGISTRAR'S SIGNATURE Baronard Hardisty		25c. DATE 15 '62	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years after the death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
05365 CERTIFICATE OF DEATH 05359													
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Annapolis				d. STREET ADDRESS 1 Epping Forest			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Charles R MORGAN			4. DATE OF DEATH Month Day Year 5 26 19 62										
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-23-14		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Post Executive				10b. KIND OF BUSINESS OR INDUSTRY Executive				11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Will J. Morgan						14. MOTHER'S MAIDEN NAME Myrtle Bradley							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES World War II						16. SOCIAL SECURITY NO. [REDACTED]							
17. INFORMANT Hospital Records						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL EDEMA 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSION, ESSENTIAL DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CIRRHOSIS OF LIVER; PULMONARY EDEMA.						INTERVAL BETWEEN ONSET AND DEATH 12 HOURS 3 MOS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 1 Jan 1962		20g. (County) Anne Arundel		20h. (State) Md.		
21. I certify that (I) (this hospital) attended the deceased from 1 Jan 1962 to 5/28/62, that (I) (we) last saw the deceased alive on 5/28/62, and that death occurred at 5/28/62, from the causes and on the date stated above.													
22a. SIGNATURE Edward S. Beck, M.D.						22b. ADDRESS 73 Franklin Street, Annapolis, Md.			22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.			22d. DATE SIGNED 5/28/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5-28-1962		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City, town or county) Arlington		23e. (State) Va			
24. FUNERAL DIRECTOR'S SIGNATURE John M. Scayler Sons Annapolis Md						25a. REC'D BY REGISTRAR DATE MAY 29 '62			25b. REGISTRAR'S SIGNATURE Arthur L. Hume				

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STATIONARY OF DAY

James M. Hall

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James M. Hall

TO DEPUTY MEDICAL EXAMINER: This certificate must be completed within 24 hours after death. If any delay is necessary, please advise the undersigned in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 05360									
1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X DAVIDSONVILLE MD.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A.A. GENERAL Hospital</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILKINS</u> First <u>Otis</u> Middle <u>Munday</u> Last					4. DATE OF DEATH Month <u>MAY</u> Day <u>11</u> Year <u>1962</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-22-1887</u>		9. AGE (In years last birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVIL SERVICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CIVIL SERVICE</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>CARY P. Munday</u>					14. MOTHER'S MAIDEN NAME <u>KATHERINE V. WILKINS</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>			16. SOCIAL SECURITY NO. <u>WWI</u>		17. INFORMANT <u>NEVA L. Munday</u>			Address <u># 3</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Cardiac</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Interval BETWEEN ONSET AND DEATH</u> DUE TO (c) <u>Sudden</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <u>19</u> o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>E. H. inhardt</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED	
EXAMINER'S NAME (Type) <u>E. H. inhardt</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL—CREMATION, REMOVAL (Specify) <u>CREMATION</u>					22b. DATE THEREOF <u>5-12-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		
22d. LOCATION (City, town, or county) (State) <u>Hyattsville MD.</u>					23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lybertus Annapolis, Md.</u>				
24a. REC'D BY REGISTRAR DATE <u>MAY 15 1962</u>					24b. REGISTRAR'S SIGNATURE <u>Cirius S. Pines</u>				

DATE SIGNED

5/16/62

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park c. LENGTH OF STAY IN lb 2 hours d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Old Gravel Pitt, 5500 Block, BelleGrove Rd.		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Park d. STREET ADDRESS 420 / 320 Holy Cross Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dennis Wayne Neilson		4. DATE OF DEATH Month May Day 6th Year 19 62	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/19/52
9. AGE (In years last birthday) 9 yrs.		10. IF UNDER 1 YEAR Months Days 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attending shhool		10b. KIND OF BUSINESS OR INDUSTRY Cumberland, Md.	
11. BIRTHPLACE (State or foreign country) Usa		12. CITIZEN OF WHAT COUNTRY? Usa	
13. FATHER'S NAME William I. Neilson Sr.		14. MOTHER'S MAIDEN NAME Virginia L. Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William I. Neilson (father)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO 929.2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) save his pail he fell in the water in trying to water			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Was fishing and his fish pail fell in the water in trying to water	
20c. TIME OF INJURY Month, Day, Year 6.30 P.M. 5/6/62 19 62		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Gravel Pitt		20f. (City or town) (County) (State) Brooklyn Park, A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/9/62	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore 25, Md.	
23. FUNERAL DIRECTOR Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR MAY 8 '62	
		24b. REGISTRAR'S SIGNATURE Glen Burnie, Md.	

100301

100301

(M)

Hopping and Winkley, Allen Burdette, MA.
Cedar Hill Cemetery
Belmont, MA.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05368 CERTIFICATE OF DEATH 05362

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22 03X-2 d. STREET ADDRESS 11 CENTER ST.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CROWNSVILLE		c. LENGTH OF STAY in 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CROWNSVILLE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle H. Last NELSON		4. DATE OF DEATH Month 5 Day 19 Year 1962	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/13/1894
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months 68 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED STEEL WORKER		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME BENI BANKS		14. MOTHER'S MAIDEN NAME IDA NELSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) U. (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 18-000000000	
17. INFORMANT RECORDS OF Address CROWNSVILLE STATE HOSP.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) known to us since 4/30/62 (c) CHRONIC BRAIN SYNDROME & CEREBRAL ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CHRONIC BRAIN SYNDROME & CEREBRAL ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH known to us since 4/30/62	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4/30/62 to 5/19/62 , 19 1962 , that (I) (we) last saw the deceased alive on 5/19/62 , 19 1962 , and that death occurred at 5 AM , from the causes and on the date stated above.			
22a. SIGNATURE L. BENEDICT M.D.		22b. DATE SIGNED 5/19/62	
22c. PHYSICIAN'S NAME (Type) L. BENEDICT M.D.		22d. ADDRESS CROWNSVILLE STATE HOSPITAL	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-24-62	
23c. NAME OF CEMETERY OR CREMATORY Cleavers Oak Cam.		23d. LOCATION (City, town or county) (State) Forkier Co. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE MORTON & DYETT		25a. REC'D BY REGISTRAR DATE MAY 23 '62	
ADDRESS 916 PENNA. AVE.		25b. REGISTRAR'S SIGNATURE Carroll S. Harris	

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NOTION & DYEING

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05369

05363

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b Few hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marley Creek		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Baltimore 26 d. STREET ADDRESS 2121 Hawkins Point Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Steven Nocar		4. DATE OF DEATH Month May Day 7th Year 1962	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-11-1894
9. AGE (In years last birthday) 67		10. IF UNDER 1 YEAR Months 3 Days 01 Hours 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fisherman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Scha		14. MOTHER'S MAIDEN NAME Telesa ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1 World War		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Anthony Butner (nephew)		Address 4043 V Street, Brooklyn	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. No eye witness, deceased was found floating on the Creek.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Marley Creek	
20f. (City or town) Glen Burnie A.A.		(County) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 5/7/62	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Glen Burnie, Md.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5/11/62	22c. NAME OF CEMETERY OR CREMATORY National	22d. LOCATION (City, town, or county) (State) Baltimore
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Fetter		24a. REC'D BY REGISTRAR DATE MAY 9 '62	
ADDRESS		24b. REGISTRAR'S SIGNATURE William S. Fetter	

MEDICAL CERTIFICATION

02

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Anne Arundel County						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville State Hld						c. LENGTH OF STAY IN 1b 6 years					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hosp						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Lucy Owens						4. DATE OF DEATH Month 5 Day 4 Year 1962					
5. SEX F		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-14-20		9. AGE (In years last birthday) 42 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (County & State, or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Henry Owens						14. MOTHER'S MAIDEN NAME Mary Owens					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO. -		17. INFORMANT Martha Peyton 2136 Walbrook Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cardiovascular Disease (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). EKG revealed evidence of previous posterior myocardial infarct 1 yr ago										INTERVAL BETWEEN ONSET AND DEATH 1 hr 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5-22-62, 1962 to 5-4-62, 1962, that (I) (we) last saw the deceased alive on 5-4-62, 1962, and that death occurred at 8:25 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Leon W. Whitt						22b. DATE SIGNED M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Leon W. Whitt						22d. ADDRESS Crownsville State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 5-9-62		23c. NAME OF CEMETERY OR CREMATORY Mt Green		23d. LOCATION (City, town or county) Baltimore		(State) Md	
24. FUNERAL DIRECTOR'S SIGNATURE A. McCrimmon 2302 NORTH AVE						25a. REC'D BY REGISTRAR DATE MAY 8 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna			

Bapt 17

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/6D

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Aa</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Millsville Md.</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Knollwood Manor</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Aa</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i> d. STREET ADDRESS <i>128 Lafayette Ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Mettie</i> Middle <i>M.</i> Last <i>Penny</i>		4. DATE OF DEATH Month <i>5</i> - Day <i>1</i> - Year <i>1962</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Apr 17 1879</i>	
9. AGE (In years last birthday) <i>83</i>		10. IF UNDER 1 YEAR Months <i>2</i> Days <i>4</i>	
11. IF UNDER 24 HRS. Hours <i>10</i> Min. <i>4</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Georgia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Newton M. Janas</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Ann Williams</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>A. Velpoe Smith</i>		18. ADDRESS <i>2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Generalized Arteriosclerosis</i> (c) <i>10 YEARS</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 HOURS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1 FEB 1962</i> to <i>1 MAY 1962</i> that (I) (we) last saw the deceased alive on <i>25 APR 1962</i> and that death occurred at <i>7:30 A.M.</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward S. Beck</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>		25c. DATE <i>MAY 3 '62</i>	

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(M)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. A fee of \$4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05372

CERTIFICATE OF DEATH

05366

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY in 1b 1 mo. 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS RFD 1, Box 170	
3. NAME OF DECEASED (Type or print) 3-#23529 Benjamin Perry		4. DATE OF DEATH Last Month Day Year 5 7 19 62	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 9, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Unknown		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4/5 19 62, to 5/7 19 62			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----- 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that (I) (this hospital) attended the deceased from 4/5 19 62, to 5/7 19 62, that (I) (we) last saw the deceased alive on 5/7 19 62, and that death occurred at P.M., from the causes and on the date stated above.			
22a. SIGNATURE <i>L. Benedict, M. D.</i>		22b. DATE SIGNED 5/8/62	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/13/1962	23c. NAME OF CEMETERY OR CREMATORY Head of Creek, Md	23d. LOCATION (City, town or county) (State) Wicomico Md
24. FUNERAL DIRECTOR'S SIGNATURE Clinton J. Stewart		25a. REC'D BY REGISTRAR DATE MAY 14 '62	
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Evans</i>			

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05373

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE ✓			
b. CITY OR TOWN (If outside corporate limits, write <small>RURAL and give nearest town</small>) FT GEORGE G MEADE				c. LENGTH OF STAY IN 1b 32 Days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 839 BERKSHIRE DRIVE				1652-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL				d. STREET ADDRESS HYATTSVILLE,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ANGELO FRANCIS PICQUADO				4. DATE OF DEATH Month May Day 10 Year 62			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 22 Sept 1914	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier				10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Picquado				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown, leave blank) Yes-27 Mar 1940 to present				16. SOCIAL SECURITY NO. 577382593			
INFORMANT Personnel Records US Army				Address Ft George G Meade, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary infarction 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post operative inguinal hernia							
INTERVAL BETWEEN ONSET AND DEATH 32 hours							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 10 May , 19 62 10 May , 19 62 that I last saw the deceased alive on 10 May , 19 62 , and that death occurred at 5:40 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David J. Kavee				DATE SIGNED 11 May 62			
PHYSICIAN'S NAME (Type) DAVID J. KAVEE, CAPTAIN, MC				KIMBROUGH ARMY HOSPITAL FEGM, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/12/62		22c. NAME OF CEMETERY OR CREMATORY Chamber's Funeral Home		22d. LOCATION (City, town, or county) (State) Riverdale, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Wolvertson				24a. REC'D BY REGISTRAR DATE MAY 17 '62			
ADDRESS 6306 - Belair Rd, Baltimore - 6, Md.				24b. REGISTRAR'S SIGNATURE Charles L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS

1938

COUNTY OF DALLAS

1938

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office.

CLERK OF DISTRICT COURT

ATTEST:

NOTARY PUBLIC

My Comm. Expires

Notary Public

Notary

John F. [unclear]

Notary Public

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05374

CERTIFICATE OF DEATH

05368

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>32 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>803 Trafalger Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles Parker PORTER</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>19</u> Year <u>1962</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>19 JAN 1886</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>03</u> Days <u>X</u>		IF UNDER 24 HRS. Hours <u>2</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CDR</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>USN RET</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Jefferson, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Frank Seeley Porter</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Travis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-1 & 2</u>				16. SOCIAL SECURITY NO. <u>Norma P Porter</u>			
17. INFORMANT <u>Norma P Porter</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Pancreas with liver metastases</u> DUE TO (b) <u>metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Unknown</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>157X</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>17 April 1962</u> to <u>19 May 1962</u> that (I) (we) last saw the deceased alive on <u>19 May 1962</u> and that death occurred at <u>P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>R.G. Williams</u>				22b. DATE SIGNED <u>20 May 1962</u>			
22c. PHYSICIAN'S NAME (Type) <u>R.G. WILLIAMS CAPT MC USN</u>				22d. ADDRESS <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 23-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Urlington National</u>		23d. LOCATION (City, town or county) (State) <u>Urlington Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				25a. REC'D BY REGISTRAR <u>DATE MAY 24 '62</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05375

CERTIFICATE OF DEATH

05369

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1 year 2 mos. 29 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1619 Druid Hill Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) 3-#23141 James H. Posey		4. DATE OF DEATH Month 5 Day 26 Year 1962		5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH February 21, 1894 9. AGE (In years last birthday) 68 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown 10b. KIND OF BUSINESS OR INDUSTRY ----- 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give year or dates of service) W.W.I		16. SOCIAL SECURITY NO. 212-14-0653 17. INFORMANT Hospital Records Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Degeneration DUE TO (b) Arteriosclerotic Hypertensive Cardiovascular Disease DUE TO (c) and Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----			
20f. (City or town) -----		(County) -----		(State) -----			
21. I certify that (I) (this hospital) attended the deceased from 8/25 19 56 5/26 1962 that (I) (we) last saw the deceased alive on 5/26 1962 and that death occurred at 8:50 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Hildegard Heard Reissman M.D.				22b. DATE SIGNED 5/28/62			
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				22d. ADDRESS Crownsville State Hospital, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-31-62		23c. NAME OF CEMETERY OR CREMATORY Shoak's Mountion S.C.			
23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE E.O. Wilson					
25a. REC'D BY REGISTRAR DATE JUN 1 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Hines					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05378 CERTIFICATE OF DEATH 05370

Item 7 Film G313 5/24/62 lmk

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn 25		c. LENGTH OF STAY IN lb Brooklyn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5603 Liberty Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle C. Last Pulley		4. DATE OF DEATH Month 5 Day 15 Year 19 62	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-96
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 05 Days 15 Hours 19 Min. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Fisher-Carr Motors		10b. KIND OF BUSINESS OR INDUSTRY Louisiana	
11. BIRTHPLACE (County & State, or foreign country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME U.S.A.		14. MOTHER'S MAIDEN NAME U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Myocardial Infarction Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Duodenal Ulcer			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1957 to May 15, 1962 , that (I) (we) last saw the deceased alive on 5/15/1962 , and that death occurred at 9:35 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Louis J. Glass M.D.		22b. DATE SIGNED May 18 '62	
22c. PHYSICIAN'S NAME (Type) Louis J. Glass, M. D.		22d. ADDRESS 320 Patapsco Ave. # 25	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-18-62	
23c. NAME OF CEMETERY OR CREMATORY Green Haven Cem		23d. LOCATION (City, town or county) (State) Green Haven, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Funeral Homes 13 E. Pratt St.		25a. REC'D BY REGISTRAR MAY 18 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

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00520

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John Henry Thompson
General

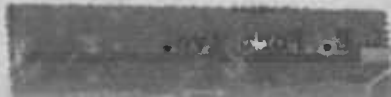
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John H. Thompson



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05371

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles O. PUMPHREY		4. DATE OF DEATH Month Day Year 5 4 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-03
9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Pumphrey		14. MOTHER'S MAIDEN NAME Elva Franklin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) 219-01-1922		16. SOCIAL SECURITY NO. 219-01-1922	
17. INFORMANT Hospital files		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary metastases 177X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Carcinoma of the prostate DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			INTERVAL BETWEEN ONSET AND DEATH 6 months 1 1/2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 5/14, 1962 to 5/14, 1962 , that (I) last saw the deceased alive on 5/14, 1962 , and that death occurred at 10:35 P. M, from the causes and on the date stated above.			
22a. SIGNATURE Richard I. Hochman		22b. DATE 5/5/62	
22c. PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d. ADDRESS Franklin Street, Annapolis, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8 May 62	23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	23d. LOCATION (City, town or county) (State) Elkridge Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		25a. REC'D BY REGISTRAR Glen Burnie Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		DATE MAY 8 '62	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Charles Fournier

1910-01-1922

Elvin Franklin

U.S.A.

Burial

8 days

Knowledge Cemetery, Chicago

John Smith

Knowledge and

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05378

05372

1. PLACE OF DEATH a. COUNTY <i>AA.</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Millersville</i> c. LENGTH OF STAY IN b. <i>1</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Knollwood</i>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>AA.</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>X Rock View Beach</i> d. STREET ADDRESS <i>1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>BENJAMIN DEASTOCK</i>			4. DATE OF DEATH Month Day Year <i>May 18 1962</i>				
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-1-82</i>	9. AGE (In years last birthday) <i>78</i> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CARPENTER</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>MD.</i>			
13. FATHER'S NAME <i>Chas.</i>			14. MOTHER'S MAIDEN NAME <i>FANNY STONE</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>FANNY STONE</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>6/18</i> 1962 to <i>6/18</i> 1962 , that (I) (we) last saw the deceased alive on <i>6/18</i> 1962 , and that death occurred at <i>6/18</i> M. from the causes and on the date stated above.							
22a. SIGNATURE <i>G. Blum</i>			22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <i>GERALD R. HUGHES</i>			22d. ADDRESS <i>121 CATHYMAN ST ANNAPOLIS MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>B</i>		23b. DATE THEREOF <i>5/11/62</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		23d. LOCATION (City, town or county) (State) <i>Belts</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Mc Gully Fun. Home</i>			25a. REC'D BY REGISTRAR DATE <i>MAY 22 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Anthony L. Thomas</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05379 CERTIFICATE OF DEATH 05373

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN b 4 mos. 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ocean City d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 3-#23216 Viola First Middle Last Reddick		4. DATE OF DEATH Month Day Year 5 17 1962	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Separated		8. DATE OF BIRTH March 21, 1932	
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 23 X 2	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11b. KIND OF BUSINESS OR INDUSTRY -----	
12. BIRTHPLACE (County & State, or foreign country) North Carolina		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME Charlie Morrison		15. MOTHER'S MAIDEN NAME Lulu	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown		17. SOCIAL SECURITY NO. Unknown	
18. INFORMANT Hospital Records		Address	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Paralytic Ileus 570.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Mechanical Obstruction of Intestines (c) DUE TO (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour 2:00 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 1/15 1962 to 5/17 1962 , that (I) (we) last saw the deceased alive on 5/17 1962 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Lionel McHenry Mapp, M. D.		22b. DATE SIGNED 5/17/62	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) 3/23/62 5/27/62		23b. DATE THEREOF 5/27/62	
23c. NAME OF CEMETERY OR CREMATORY Mecklenburg County, N.C.		23d. LOCATION (City, town or county) (State) Charlotte, N.C.	
24. FUNERAL DIRECTOR'S SIGNATURE Brown & Sons Funeral Home		25a. REC'D BY REGISTRAR MAY 25 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		DATE May 25 '62	

MEDICAL CERTIFICATION

15-10

15-10

James Arndel

Montevideo

Montevideo State Hospital

Montevideo

Female

Montevideo

Granite Mountain

Unknown

Private Home

Technical Department of Industries

115 5:30 PM

x

James Arndel

Montevideo

Montevideo

Montevideo

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

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MAY 29 1962
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05380

05374

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 Holly ave Severna Park 35 yrs X Severna Park Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>OR INSTITUTION</u>		d. STREET ADDRESS <u>1 Holly ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jane Whitelock Regester</u>		4. DATE OF DEATH Month <u>5</u> Day <u>27</u> Year <u>1962</u>	
S. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 24 1879</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Robert Oliver</u>		14. MOTHER'S MAIDEN NAME <u>Miss Edeline Cormier</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-30-5645</u>	
17. INFORMANT <u>SON OLIVER REGESTER, SEVERNA PARK</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sen. Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1956</u> 19 <u>30</u> to <u>1962</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>5-26</u> 19 <u>62</u> and that death occurred at <u>12 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>5-27-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>		22d. ADDRESS <u>Severna Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/29/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOWARD W. HUBBARD</u>		ADDRESS <u>1107 WILKINS AVE</u>	
25a. REC'D BY REGISTRAR DATE <u>MAY 29 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Lincoln S. Thomas</u>	

03030

STATE OF NEW YORK

03030

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05381

CERTIFICATE OF DEATH

05376

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 45 Madison Place			
3. NAME OF DECEASED (Type or print) First Magdalene Middle ROBINSON Last ROBINSON				4. DATE OF DEATH Month May Day 13 Year 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 31, 1882	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.							
13. FATHER'S NAME Joseph A. Jackson				14. MOTHER'S MAIDEN NAME Mary Jane Jamison			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. n9 none		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute posterior myocardial infarction 422.1 DUE TO (b) infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) arteriosclerotic CVD DUE TO (c) arteriosclerotic CVD				INTERVAL BETWEEN ONSET AND DEATH 18 hr 10 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (Robinson) attended the deceased from 1954 , 19 to May 13, 1962 , that (I) (X) last saw the deceased alive on May 13, 1962 , and that death occurred at 11:05 PM , from the causes and on the date stated above.							
22a. SIGNATURE Frank M. Shipley M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/14/62	
22c. PHYSICIAN'S NAME (Type) Frank M. Shipley, M.D.				22d. ADDRESS 121 Cathedral St., Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 16, 1962		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town or county) (State) Annapolis, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.				25a. REC'D BY REGISTRAR MAY 18 '62		25b. REGISTRAR'S SIGNATURE Arthur L. House	

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TO HOSPITAL FOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
05382					05378					
1. PLACE OF DEATH a. COUNTY <u>Pine Arundel.</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institutions, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>7 years.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore.</u>			3v01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address of institution) <u>Plaza Manor Nursing Home.</u>					d. STREET ADDRESS <u>2548 Francis Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Offie</u> First Middle Last <u>ROGERS</u>					4. DATE OF DEATH <u>May</u> Month <u>3rd</u> Year <u>1962</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/21/87</u>		9. AGE (In years last birthday) <u>83</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Midwife.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Granite, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Jerry Hall</u>					14. MOTHER'S MAIDEN NAME <u>Martha Davis.</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO (b) <u>Generalized Arteriosclerosis.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u> (c) <u>Chronic Brain Syndrome due to Cerebral Arteriosclerosis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>—</u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While of work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>4/8/1955</u> to <u>5/3/1962</u> that (I) (we) last saw the deceased alive on <u>5/3/1962</u> , and that death occurred at <u>12:40 p.m.</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>Lionel M. Henry Mapp</u>					22b. DATE SIGNED <u>5/3/62</u>					
22c. PHYSICIAN'S NAME (Type) <u>Lionel M. Henry Mapp, M.D.</u>					22d. ADDRESS <u>20 Dean Street, Annapolis Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-7-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>A.M.E. ZION</u>			23d. LOCATION (City, town, or county) (State) <u>Granite, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>					ADDRESS <u>802 Mad. Ave., Balto., Md.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 7 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Lincoln L. Thomas</u>	

00332

CERTIFICATE OF DEATH

00332

(M)

John Doe
Age 45
Born [illegible]
Died [illegible]
Cause of Death [illegible]
Place of Death [illegible]
Signature [illegible]
Date [illegible]

[illegible text]

[illegible text]

[illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena	
c. LENGTH OF STAY in 1b 13 yrs.		d. STREET ADDRESS RFD 2, Box 245	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD 2, Box 245		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emil A. Schanken		4. DATE OF DEATH May 18, 1962	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hardwood Finisher		10b. KIND OF BUSINESS OR INDUSTRY Furniture	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Schanken		14. MOTHER'S MAIDEN NAME Bertha Sandusky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-07-0981	
17. INFORMANT Mrs Ada Schanken same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebral thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) generalized arteriosclerosis DUE TO (c) 332X		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the prostate gland - 1 month		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 15, 1950 to May 18, 1962 , that (I) (we) last saw the deceased alive on May 17, 1962 , and that death occurred at 6 A.M. from the causes and on the date stated above.			
22a. SIGNATURE R. M. McLaughlin		22b. DATE SIGNED 5/18/62	
22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin		22d. ADDRESS 3708 Mountain Rd. Pasadena, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF May 21, 1962	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial	23d. LOCATION (City, town or county) (State) Glen Burnie, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		25. REC'D BY REGISTRAR May 22 '62	
25. REGISTRAR'S SIGNATURE Charles J. Hume			

05513

05513

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A one hundred



Paradise

13 yrs.

Paradise

RED 2, Box 205

RED 2, Box 205

May 17, 1962

Schenck

A.

Emil



W

Nov. 6, 1884

Male White

USA

Baltimore, Md.

Township

Barwood Pindar

Bertie Sanduly

Charles Schenck

Mr. Ada Schenck same as 2

215-07-0981

No

May 21, 1962 Glen Haven Memorial, Glen Burnie, Md.

May 21, 1962 Glen Haven Memorial, Glen Burnie, Md.

Emil

Hopkins and Kinkley, Glen Burnie, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05384 CERTIFICATE OF DEATH 05380

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 7 mos. 26 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 705 W. Lanvale Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) 3-#19060 Helen M. Scott		4. DATE OF DEATH Month 5 Day 28 Year 19 62	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1892
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Samuel Friend	
14. MOTHER'S MAIDEN NAME Cornelius Jeter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. Unknown		17. INFORMATION Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) 491X (c) Dehydration PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that (I) (this hospital) attended the deceased from 10/2 19 58 to 5/28 19 62 , that (I) (we) last saw the deceased alive on 5/28 19 62 , and that death occurred 2:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Lionel McHenry Mapp, M. D.		22b. DATE SIGNED 5/28/62	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 1-1962	
23c. NAME OF CEMETERY OR CREMATORY Arbutus Men. P.R.		23d. LOCATION (City, town or county) (State) Arbutus, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Earl Gilmore		25a. REC'D BY REGISTRAR JUN 1 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hume			

1954

M

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MEMORANDUM FOR THE RECORD
SUBJECT: [Illegible]
DATE: [Illegible]
BY: [Illegible]
TO: [Illegible]
[The following text is extremely faint and largely illegible, appearing to be a memorandum or report. It contains several lines of text, some of which are underlined, and a large signature or stamp in the lower right quadrant.]

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

<div> <div> <div>1</div> <div>05385</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> <div> <div>05381</div> </div> </div>											
1. PLACE OF DEATH a. COUNTY Maryland b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Linthicum c. LENGTH OF STAY in 1b Few minutes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Friendship Airport						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE California b. COUNTY Berkeley c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Berkeley d. STREET ADDRESS 176 Alvarado Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Clarence Arthur Shuey First Middle Last 5. SEX M 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 1/8/81 9. AGE (In years last birthday) 81 Yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 19 62						4. DATE OF DEATH May 7 1962 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) California 12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME John Shuey 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)						14. MOTHER'S MAIDEN NAME Barbara Mathuson 16. SOCIAL SECURITY NO. 17. INFORMANT Adm. Allen Shinn, 3038 O St. NW Address Washington, D.C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour e.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Gustave H. Faubert</i> M.D. EXAMINER'S NAME (Type) Gustave H. Faubert, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/7/62 Address (Street, city, town, or county) Glen Burnie, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 22b. DATE THEREOF 5/8/62 22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery 22d. LOCATION (City, town, or country) (State) Baltimore, Md.											
23. FUNERAL DIRECTOR Hopping and Kirkley, Glen Burnie, Md. 24a. REC'D BY REGISTRAR DATE MAY 8 '62 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoms</i>											

MEDICAL EXAMINATION CERTIFICATE OF DEATH

196 Riverside Road

Berkeley

California

Barbara Johnson

Adm. Allen Smith, 3000 S. W.

Greenwood Cemetery, Berkeley, Cal.

Continuation 5/6/62

Hopping and Kirkley, Glen Elgin, Ill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05386

CERTIFICATE OF DEATH

05382

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenburnie</u>		c. LENGTH OF STAY in 1b <u>14 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenburnie</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Nabbs Creek Road Box #159</u>				d. STREET ADDRESS <u>Nabbs Creek Road</u>			
3. NAME OF DECEASED (Type or print) <u>Barbara</u> First <u>0</u> Middle <u>Silenskis</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>30</u> Year <u>19 62</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 4, 1886</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>Lithuania</u>	
13. FATHER'S NAME <u>Deceased</u>				14. MOTHER'S MAIDEN NAME <u>Deceased</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic C.V. disease</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>08</u> <u>1958</u> to <u>5/29</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>5/8</u> <u>1962</u> , and that death occurred at <u>7A</u> <u>AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Sidney R. Fehlert</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>SIDNEY R. FEHLERT</u>				22d. ADDRESS <u>4780 Kensington Dr.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 2, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>		23d. LOCATION (City, town or county) (State) <u>Dundalk, Maryland</u>	
24. GENERAL DIRECTOR'S SIGNATURE <u>Charles W. Kachauskas</u>				25a. REC'D BY REGISTRAR <u>4 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

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Chlorine and Hydrogen Chloride

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05383

05383

1. PLACE OF DEATH a. COUNTY <u>Galesville</u> <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Galesville</u> d. STREET ADDRESS <u>Galesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>-----</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ernest H. Smith</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 12, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Carpenter</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Smith</u>	
14. MOTHER'S MAIDEN NAME <u>Betty Wayson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mrs Edward F. Mauk- Daughter- same as # 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> 163X Conditions, if any, which gave rise to immediate cause (b) <u>-----</u> (c) <u>-----</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>-----</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>-----</u>		20c. TIME OF INJURY Month, Day, Year <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	
20f. (City or town) <u>-----</u> (County) <u>-----</u> (State) <u>-----</u>		21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1961</u> , to <u>May 29, 1962</u> that (I) (we) last saw the deceased alive on <u>May 20, 1962</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Willard F. Smith</u> M.D.		22b. DATE SIGNED <u>5/29/62</u>	
22c. PHYSICIAN'S NAME <u>WILLARD F. SMITH MD</u>		22d. ADDRESS <u>Shady Side, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 31, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodfields Cemetery</u>		23d. LOCATION (City, town or county) <u>Galesville, Md.</u> (State) <u>-----</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Don Hopping</u> ADDRESS <u>Hopping Funeral Home Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 1 1962</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Haines</u>	

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Government of Guyana

WILLARD F. SMITH MR
Minister of Health

Shelly Side, Guyana

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND
CERTIFICATE OF DEATH

05388

05384

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY in lb 35 Min.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 1112 Leonard Drive	
3. NAME OF DECEASED (Type or print) First Middle Last SOLLEY		4. DATE OF DEATH Month Day Year May 3 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1962
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) yrs. Months Days Hours Min. 35	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Buren Elsworth SOLLEY		12. CITIZEN OF WHAT COUNTRY? U.S.	
14. MOTHER'S MAIDEN NAME Jacqueline Ellen Smeltz		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or date of service) No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 239X IMMEDIATE CAUSE (a) TUMOR MASSIVE TYPE UNDETERMINED, ORIGINATING FROM ORAL CAVITY Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PREMATURITY		INTERVAL BETWEEN ONSET AND DEATH FROM BIRTH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 5-3, 1962 to 5-3, 1962	
21. I certify that (I) (this hospital) attended the deceased from 5-3, 1962 to 5-3, 1962 that (I) (we) last saw the deceased alive on 5-3, 1962 and that death occurred at 11:20 PM from the causes and on the date stated above.			
22a. SIGNATURE Raymond P. Srsic		22b. DATE SIGNED 5-4-62	
22c. PHYSICIAN'S NAME (Type) Raymond P. Srsic		22d. ADDRESS 48 Balto-Anna. Blvd., Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 5/4/62		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Maryland Anatomy Board		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Raymond C Fink		25a. REC'D BY REGISTRAR MAY 16 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

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James V. Brown

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05385

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>1 9 Acorn Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Helena</u> Middle <u>B. (Lockett)</u> Last <u>SOWERS</u>			4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1962</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1900</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>Thaddeus Lockett</u>				
14. MOTHER'S MAIDEN NAME <u>Mary Ellen Britton</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				
16. SOCIAL SECURITY NO. <u>214 05 1253</u>			17. INFORMANT Address <u>Mr. Jack Sowers- Husband- same as # 2</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Left ventricular failure</u> DUE TO (b) <u>Arterio sclerotic heart disease</u> DUE TO (c) <u>Myocardial infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Myocardial infarct</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) 	(County) 	(State) 		
21. I certify that (I) (the doctor) attended the deceased from <u>November 1961</u> , to <u>May 15, 1962</u> , that (I) (the doctor) saw the deceased alive on <u>May 15, 1962</u> , and that death occurred at <u>11:25 AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Gerard Church</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>GERARD CHURCH</u>		22b. DATE SIGNED <u>5/15/62</u> 22d. ADDRESS <u>121 Cathedral St., Annapolis, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 18, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>			
23d. LOCATION (City, town or county) <u>Annapolis, Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>					
25a. REC'D BY REGISTRAR <u>MAY 21 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the death certificate is not completed and signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
Item 8 Film G314 6/4/62 iwk															
1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 2 Bloomsbury Sq. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN b 10				d. STREET ADDRESS 2 Bloomsbury Sq.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FLONILLA A. SWONTEK				4. DATE OF DEATH May 22 1962				5. SEX Female				6. COLOR OR RACE White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Aug. 25, 1919				9. AGE (In years last birthday) 42 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife			
11. BIRTHPLACE (County & State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME William H. Sutphin				14. MOTHER'S MAIDEN NAME Elizabeth McGomery			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. ?				17. INFORMANT Mr. John Swontek- Husband				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 081X Post Polio Paralysis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 6-6-1952 to 5-22-1962 , that (I) (we) last saw the deceased alive on April 3, 1962 and that death occurred at 4:22 AM , from the causes and on the date stated above.			
22a. SIGNATURE Edith Rodler				22b. DATE May 23, 1962				22c. PHYSICIAN'S NAME (Type) Edith Rodler				22d. ADDRESS 45 Franklin Street, Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 25, 1962				23c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial				23d. LOCATION (City, town or county) (State) Annapolis, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home				25a. REC'D BY REGISTRAR MAY 28 '62				25b. REGISTRAR'S SIGNATURE Carlton L. Hanna				25c. ADDRESS Annapolis, Maryland			

04380

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05391

CERTIFICATE OF DEATH

05387

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>C. A.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>10 Nabelle Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Tasker</u>		4. DATE OF DEATH Month Day Year <u>May 3 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1962</u>
9. AGE (In years last birthday) <u>2</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tasker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mack Samuel Galloway</u>		14. MOTHER'S MAIDEN NAME <u>Heneritta Tasker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>776X</u>	
17. INFORMANT <u>Hospital records</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prevalence & Immaturity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-3-62</u> , 19 <u>62</u> , to <u>5-3-62</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>5-3-62</u> , 19 <u>62</u> , and that death occurred at <u>5-3-62</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. T. Allen</u>		22b. DATE SIGNED <u>5/3/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		22d. ADDRESS <u>Cathedral St., Annapolis, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 5-9-1962</u>		23b. DATE THEREOF <u>5-9-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		23d. LOCATION (City, town or county) <u>Annapolis Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese #</u>		25a. REC'D BY REGISTRAR <u>May 15 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		25c. ADDRESS <u>Annapolis Md</u>	

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RECEIVED AT DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05392 CERTIFICATE OF DEATH 05388

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena		c. LENGTH OF STAY in lb 3 yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena (Bayside Beach)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Linthicum Road				d. STREET ADDRESS Linthicum Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Edward Towner Jr.				4. DATE OF DEATH Month May Day 19 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1904		9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Balte. Transit		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Edward Towner				14. MOTHER'S MAIDEN NAME Nancy Lee Benson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 213-10-2886		17. INFORMANT Mrs. Catherine Towner Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinoma DUE TO (b) adenocarcinoma, primary site DUE TO (c) undetermined, believed to be pancreas PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) none							
19. INTERVAL BETWEEN ONSET AND DEATH 1 year 1 year							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/18, 1962 to 5/19, 1962 , that (I) (we) last saw the deceased alive on 5/18, 1962 , and that death occurred at 7 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE R. M. McLaughlin				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/21/62	
22c. PHYSICIAN'S NAME (Type) R. M. McLaughlin				22d. ADDRESS 3108 Mountain Rd. Pasadena, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 22, 1962		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City, town or county) (State) Ritchie Hwy. A. A. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE George J. Gonce				ADDRESS 4001 Ritchie Hwy. (25)		25a. REC'D BY REGISTRAR MAY 23 '62	
						25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>Tracy's Landing</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tracy's Landing</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tracys Landing</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM RILEY TUCKER</u>		4. DATE OF DEATH Month Day Year <u>May 16 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 8, 1885</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Riley Tucker</u>		14. MOTHER'S MAIDEN NAME <u>Martha King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Martha T. Gibson, Tracys Landing, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>chronic occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>generalized arteriosclerosis -</u> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Emily H. Wilson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Emily H. Wilson</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <u>5/18/62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 19, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Harmony Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Owings, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home Owings Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAY 22 '62</u>		DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05394											
05390											
Item 9 Film G313 5/23/62 iwk											
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 1 mo. 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Crownsville State Hospital						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton d. STREET ADDRESS Unknown Hammond Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) 3-#23511 Henry E. Turner						4. DATE OF DEATH Month 5 Day 16 Year 19 62					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1875 - Dec. 21, 86 BT		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 5 Days 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown School teacher Retired				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown Charles Turner						14. MOTHER'S MAIDEN NAME Unknown Harriet Turner					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Unknown No				16. SOCIAL SECURITY NO. 203-01-8434		17. INFORMANT Unknown Hospital Records Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cardiac Decompensation											
443X DUE TO Arteriosclerotic Hypertensive Cardiovascular Disease											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with above											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 19 62 Hour a.m. 8:00 p.m. 5/16											
2Dd. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>											
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) Easton (County) md. (State)											
21. I certify that (I) (this hospital) attended the deceased from 3/31 8:00 1962 , to 5/16 1962 , that (I) (we) last saw the deceased alive on 5/16 1962 , and that death occurred at 8:00 1962 , from the causes and on the date stated above.											
22a. SIGNATURE Hildegard Heard Reissman M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 5/16/62		
22c. PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. Crownsville State Hospital, Maryland						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF MAY 19, 1962											
23c. NAME OF CEMETERY OR CREMATORY Richards Cemetery											
23d. LOCATION (City, town or county) Easton, Md. (State)											
24. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell-Easton md						25a. REC'D BY REGISTRAR MAY 21 '62			25b. REGISTRAR'S SIGNATURE Arthur S. Haines		

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Charles E. Kiser
San/Johns District

United States District Court

1982

May 1982
Richard E. Kiser

CERTIFICATE OF DEATH

Reg. Dist. No.

05395

05391

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write FT GEORGE G MEADE) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOZMAN d. STREET ADDRESS - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Julia Middle Lackey Last VanBibber		4. DATE OF DEATH Month May Day 16 Year 1962	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 10, 1908
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 20 Days 08	IF UNDER 24 HRS. Hours 12 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Same	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME M.O. Lackey		14. MOTHER'S MAIDEN NAME Mary Myer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT (Daughter)		Address Mrs Mary Jane VanBibber Orr Bozman, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the ovary DUE TO 175.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 14 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from April 1961 to 16 May 1962 , that I last saw the deceased alive on 16 May 1962 , and that death occurred at 6:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE David J. Kavee MC MC		ADDRESS (Street, city or town, state) KIMBROUGH ARMY HOSPITAL FT G G MEADE, MD DATE SIGNED _____	
PHYSICIAN'S NAME (Type) DAVID J. KAVEE, CAPTAIN, MC		KIMBROUGH ARMY HOSPITAL FT G G MEADE, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	May 19, 1962	Speciation Cemetery	Perryman Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William Conahan, Laurel Md		24a. REC'D BY REGISTRAR DATE MAY 22 '62	24b. REGISTRAR'S SIGNATURE Arthur S. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7542 • J. Neurosci., September 24, 2008 • 28(39):7536–7544

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

05392

05392

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pasadena	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Medary A		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Robert First Crafton Middle Wade Last		4. DATE OF DEATH Month MAY Day 13 Year 1962	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1924
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months 5 Days 12 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor - Telco		10b. KIND OF BUSINESS OR INDUSTRY Same	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Crafton Wade		14. MOTHER'S MAIDEN NAME Lois Catherine Shoeler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes		16. SOCIAL SECURITY NO. WW II	
17. INFORMANT Lois Catherine Wade		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 288X DUE TO Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gout DUE TO (c) Gout	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 min 2 yrs. 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) (County) (State) —	
21. I certify that (I) (this hospital) attended the deceased from 6/8 1958 to 5/13/62 that (I) (we) last saw the deceased alive on 3/28 1962 and that death occurred at M from the causes and on the date stated above.			
22a. SIGNATURE R. W. RICHARD		22b. DATE SIGNED 5/13/62	
22c. PHYSICIAN'S NAME (Type) R. W. RICHARD		22d. ADDRESS 715-Corrier Rd Glen Burnie	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/16/62	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial		23d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley		25a. REC'D BY REGISTRAR DATE 17 '62	
25b. REGISTRAR'S SIGNATURE Chelms L. House			

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[Faint, illegible handwriting covering the main body of the page]

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CERTIFICATE OF DEATH

05393

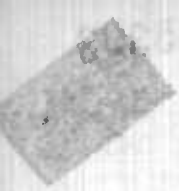
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE				c. LENGTH OF STAY IN 1b -			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KIMBROUGH ARMY HOSPITAL				d. STREET ADDRESS JACKSON GROVE RD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAVID Middle FRANK Last WALKER				4. DATE OF DEATH Month 25 Day MAY Year 1962			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6 April 1899	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service(Retired)				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes-Dates unknown				16. SOCIAL SECURITY NO. Unknown		INFORMANT (Son) LeRoy Walker Jackson Grove Rd Odenton, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 260 X DUE TO Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes (c) ?						INTERVAL BETWEEN ONSET AND DEATH 18 days 1-2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5/14 , 19 62 , to 5/25 , 19 62 , that I lost saw the deceased alive on 5/25 , 19 62 , and that death occurred at 4 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 203 West Maple Rd Linthicum Heights, Md DATE SIGNED 5/25/62							
ACTUAL SIGNATURE Chas. L. Ball Jr.				M.D. 203 West Maple Rd Linthicum Heights, Md			
PHYSICIAN'S NAME (Type) Charles L. Ball				MD 203 West Maple Rd Linthicum Heights, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 28 May 1962		22c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem.		22d. LOCATION (City, town, or county) (State) Fort Meyer, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE R. J. English				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE MAY 29 '62	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN lb 10 mos. 28 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland		f. COUNTY Baltimore City		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 125 Colvin Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		First John		Middle M		Last Washington		4. DATE OF DEATH 5		Month 27		Day 19		Year 62	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 30, 1894		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe-Fitter		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME John Washington		14. MOTHER'S MAIDEN NAME Roberta													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1917-1919		16. SOCIAL SECURITY NO. 217-09-3112		17. INFORMANT Hospital Records		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 715X DUE TO Septicemia Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO Decubitus Ulcers														INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Parkinson's Disease														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----													
20c. TIME OF INJURY Hour e.m. p.m. ----- 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) -----		(County) -----		(State) -----					
21. I certify that (I) (this hospital) attended the deceased from 6/5 9:25 to 5/27 , 19 62 , that (I) (we) last saw the deceased alive on 5/27 , 19 62 , and that death occurred at p.m. from the causes and on the date stated above.															
22a. SIGNATURE Lionel McHenry Mapp		22b. DATE SIGNED 5/28/62		22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		22d. ADDRESS Crownsville State Hospital, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/1/62		23c. NAME OF CEMETERY OR CREMATORY MT Calvary Cem.		23d. LOCATION (City, town or county) Frederick Md.		(State) Md.							
24. FUNERAL DIRECTOR'S SIGNATURE E.O. Wilson		ADDRESS 1060 Brantley Ave.		25a. REC'D BY REGISTRAR DATE MAY 31 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Hume									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
05399									
05395									
CERTIFICATE OF DEATH									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE			c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEORGE G MEADE				
d. NAME OF HOSPITAL (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL					d. STREET ADDRESS 7234D JOHNSTON ST			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LEONARD Middle JEROME Last WASHINGTON					4. DATE OF DEATH Month May Day 9 Year 19 62				
5. SEX Male		6. COLOR OR RACE Negroid		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1961		9. AGE (In years last birthday) yrs. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) GERMANY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME LOUIS WASHINGTON JR					14. MOTHER'S MAIDEN NAME MARY LEE MAJOR				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. -		INFORMANT Father		Address 7234D Johnston St FGGM, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 223 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hydrocephalus DUE TO (c) Sturge-Weber Disease								INTERVAL BETWEEN ONSET AND DEATH Congenital Congenital	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 May 19 62 to 9 May 19 62 , that I last saw the deceased alive on 9 May 19 62 , and that death occurred at 9:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED WILLIAM B. SEMBROT, CAPTAIN, MC KIMBROUGH ARMY HOSPITAL FT GEORGE G MEADE WILLIAM B. SEMBROT, CAPTAIN, MC KIMBROUGH ARMY HOSPITAL FT GEORGE G MEADE									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-15-62		22c. NAME OF CEMETERY OR CREMATORY Long Point Cem		22d. LOCATION (City, town, or county) (State) MT Pleasant, S.C.			
23. FUNERAL DIRECTOR'S SIGNATURE Chas O. Wilson ADDRESS Brimley Ave						24a. REC'D BY REGISTRAR DATE MAY 14 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
05400					05396						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY <i>Anne Arundel</i>					a. STATE <i>MD</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					b. COUNTY <i>AA</i>						
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
<i>DEALE</i>					<i>X DEALE</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS						
					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			<i>Robert</i>		<i>Owen</i>		<i>Welch</i>		<i>May 20 1962</i>		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
<i>Male</i>		<i>White</i>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>3/13/02</i>		<i>60</i> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>WATERMAN & Farmer</i>				<i>Seafood - Tobacco</i>				<i>Deale Md.</i>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
<i>Thomas F. Welch</i>				<i>IDA MAE DEALE</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
<i>No</i>				<i>218 36 3931</i>		<i>EDNA M. WELCH DEALE MD</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of lung & metastases</i> <i>163X</i> DUE TO (b) <i>to neck and lumbar vertebrae</i> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour e.m. p.m.		<i>19</i>		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1, 1961</i> , to <i>May 20, 1962</i> that (I) (we) last saw the deceased alive on <i>May 19, 1962</i> , and that death occurred at <i>8:30 AM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Willard F. Smith</i>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>5/21/62</i>			
22c. PHYSICIAN'S NAME (Type) <i>WILLARD F. SMITH, MD</i>						22d. ADDRESS <i>Shady Side, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
<i>Burial</i>		<i>May 22, 1962</i>		<i>Deale</i>		<i>Deale Md.</i>					
24. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty</i>						25a. REC'D BY REGISTRAR DATE <i>MAY 29 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>			

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UNITED STATES OF AMERICA

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TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 05397									
1. PLACE OF DEATH a. COUNTY <i>AA</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>A. A. General Hospt.</i>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>AA</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i> d. STREET ADDRESS <i>1180 Tyler Ave</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Emma Roberta Windsor</i> First Middle Last					4. DATE OF DEATH Month <i>5</i> - Day <i>29</i> - Year <i>1962</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-12-1897</i>		9. AGE (In years last birthday) <i>64</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>AA, Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Robert Price</i>					14. MOTHER'S MAIDEN NAME <i>Emma Avery</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>					16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Leslie H. Windsor</i> Address <i>52</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>434.4</i> DUE TO <i>Ladric</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Stroke</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Interval between onset and death</i>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <i>19</i> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>E. Linhardt</i> EXAMINER'S NAME (Type) <i>E. Linhardt</i>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>5-28-62</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 1-62</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt Zion Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Mt Zion Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Son</i> ADDRESS <i>Annapolis Md</i>					24a. REC'D BY REGISTRAR DATE <i>JUN 4 '62</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur P. Hume</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05402

05398

1. PLACE OF DEATH a. COUNTY AA b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEALE c. LENGTH OF STAY IN 1b 52 YRS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE MD b. COUNTY AA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEALE d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Hattie L Windsor				4. DATE OF DEATH May 15 1962			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 2 1871	
9. AGE (In years last birthday) 90		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmistress		11. BIRTHPLACE (County & State, or foreign country) Tyaskin Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ISAAC J. STREET				14. MOTHER'S MAIDEN NAME MARY CATLIN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT NORMA WINDSOR DEALE MD Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Permeous anemia				INTERVAL BETWEEN ONSET AND DEATH 24 hours year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to May 15, 1962 , that (I) (we) last saw the deceased alive on May 14 1962 , and that death occurred at 2 AM , from the causes and on the date stated above.							
22a. SIGNATURE Willard F. Smith				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5/15/62	
22c. PHYSICIAN'S NAME (Type) WILLARD F. SMITH				22d. ADDRESS Shady Side, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF MAY 17 1962		23c. NAME OF CEMETERY OR CREMATORY SHERBERT		23d. LOCATION (City, town or county) (State) DEALE MD	
24. FUNERAL DIRECTOR'S SIGNATURE Bernard Harduty ADDRESS Salisbury Lef				25a. REC'D BY REGISTRAR MAY 21 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

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CHURCHMAN OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05403 CERTIFICATE OF DEATH 05399

1. PLACE OF DEATH e. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 44 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) #700 Stewart Ave., S.W.		d. STREET ADDRESS #700 Stewart Ave., S.W.	
3. NAME OF DECEASED (Type or print) WILHELMINA C. WOCKENFUSS		4. DATE OF DEATH May 1, 1962	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 11th April 1878
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gotlieb Engler		14. MOTHER'S MAIDEN NAME Henrietta Schutke	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Alma Lietzau		Address Glen Burnie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 443X DUE TO cerebral hemorrhage Hypertension Cardio-Vascular Dis. Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-27 to 4-30, 1962, that (I) (we) last saw the deceased alive on 4-30-62, and that death occurred at 2 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Charles R. MacDonald, M.D.		22b. DATE SIGNED 5-1-62	
22c. PHYSICIAN'S NAME (Type) Charles R. MacDonald, M.D.		22d. ADDRESS 202 Crain Highway, Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4th May 1962	
23c. NAME OF CEMETERY OR CREMATORY St. Paul's Ch. Cemetery		23d. LOCATION (City, town or county) (State) Violetteville, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Richard E. Single		25a. REC'D BY REGISTRAR MAY 3 '62	
ADDRESS Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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(M)

Time (min)

Time (min)

Dist. (miles)

Count (v)

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Count (v)

Count (v)

Count (v)

General Summary
Hydrogen Chloride

4-27 05 1-30 03

4-27 05 1-30 03

C. R. Michael

303 Green Highway, New York, N.Y.

Charles R. Michael, N.Y.

Charles R. Michael, N.Y.

Elan Borale, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
05404 CERTIFICATE OF DEATH 05400

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residencia before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL St. Margarets</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Margarets Rd.</u>		d. STREET ADDRESS <u>St. Margarets Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>NEOMA</u> Middle <u>E.</u> Last <u>Wollett</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>		8. DATE OF BIRTH <u>APRIL 23rd 1913</u>	
6. COLOR OR RACE <u>W</u>		9. AGE (In years last birthday) <u>49</u> yrs.	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM KNOWLES</u>		14. MOTHER'S MAIDEN NAME <u>ROSA JAMES</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>CHARLES B. Wollett</u>		Address <u># 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breast, RX.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 1/2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-14-59</u> , 19 <u>62</u> to <u>5-21-</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>5-21-1962</u> and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.			
22. SIGNATURE <u>James R. Martin</u>		22b. DATE SIGNED <u>5-23-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		22d. ADDRESS <u>65 SHAW ST. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-24-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Margarets</u>		23d. LOCATION (City, town or county) (State) <u>St. Margarets MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. By...</u>		24. ADDRESS <u>Annapolis, Md.</u>	
25a. REC'D BY REGISTRAR <u>MAY 25 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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FOR STATE
HEALTH DEPT
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please secure the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05405

05401

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Linthicum c. LENGTH OF STAY IN 1b 7 y d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 5 Eleanor Avenue		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Raymond Yost		4. DATE OF DEATH May 20th 19 62	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/8/06
9. AGE (In years last birthday) 56		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Engineer		10b. KIND OF BUSINESS OR INDUSTRY Md. Match	
11. BIRTHPLACE (State or foreign country) Pittsburg, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Yost		14. MOTHER'S MAIDEN NAME Martha Carrick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) from 1925 to 1939		16. SOCIAL SECURITY NO. 214-18-7429	
17. INFORMANT Mrs. Anna Yost (wife)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Has had coronary diseases since 1955. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/20/62 Address (Street, city, town, or county) Glen Burnie, Md.			
ACTUAL SIGNATURE Gustave H. Faubert, M.D.		EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 23, 1962	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Rd. Balto. Md.	
23. FUNERAL DIRECTOR George J. Gonce ADDRESS 4001 Ritchie Hwy. (25)		24a. REC'D BY REGISTRAR DATE MAY 25 '62	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased may be retained by the hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orchard Bch.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Orchard Beach	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1919 West End. Dr.		d. STREET ADDRESS 7919 West End Dr.	
3. NAME OF DECEASED (Type or print) Henry N. Zeller		4. DATE OF DEATH Month 5 Day 31 Year 19 62	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-2-1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10b. KIND OF BUSINESS OR INDUSTRY MD	
11. BIRTHPLACE (County & State, or foreign country) MD		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Zeller		14. MOTHER'S MAIDEN NAME Sophie Belto	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Family	
17. INFORMATION Address Same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiac Vascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1961 to May 31, 1962, that (I) (we) last saw the deceased alive on May 29, 1962, and that death occurred at 3:00 PM, from the causes and on the date stated above.			
22a. SIGNATURE J. Brady Smith M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. BRADY SMITH		22d. ADDRESS Pasadena Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) B	23b. DATE THEREOF 6-4-62	23c. NAME OF CEMETERY OR CREMATORY Glen View Cem	23d. LOCATION (City, town or county) (State) Glen Burnie Md
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes		25a. REC'D BY REGISTRAR DATE JUN 4 '62	
ADDRESS 130 E. Fort Ave.		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

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